DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) POLICY

Document Summary

This policy is intended as a positive step to help a person’s wishes in regard to cardio-pulmonary resuscitation (CPR).

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Important Note:
The Intranet version of this document is the only version that is maintained.
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1 SCOPE

This policy applies to all clinical staff within the Cumbria Partnership NHS Foundation Trust.

2 INTRODUCTION

The primary goal of healthcare is to benefit patients by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, leads to more harm or burden than benefit (from the patient’s perspective), ceases to benefit the patient, or if an adult with capacity has refused treatment, that treatment is no longer justified.

Prolonging a person's life usually provides a health benefit to that person. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or to the potential harms and burdens of treatment. The decision to use a treatment should be based on the balance of risks and benefits to the individual receiving the treatment. This principle applies to any treatment, including cardiopulmonary resuscitation (CPR).

CPR is undertaken in an attempt to restore spontaneous circulation and breathing in a person in cardiac and/or respiratory arrest. CPR is an invasive and traumatic medical intervention and usually includes chest compressions, attempted defibrillation, and injection of drugs and ventilation of the lungs. In some cases spontaneous circulation may be restored by prompt defibrillation alone. The proportion of people who survive cardiorespiratory arrest following CPR is relatively low. In hospital, the chance of surviving cardiorespiratory arrest to discharge varies considerably and depends on many factors, including co-morbidities and the cause and circumstances of the arrest. In most hospitals the average survival to discharge is in the range of 15-20%.

Where cardiac arrest occurs out of hospital and resuscitation is attempted, the average survival rate is lower, usually 5-10%.

As with in-hospital arrest the probability of success depends on many factors including the cause of the arrest, how soon after the arrest CPR is started, and the subsequent availability of resuscitation equipment and trained personnel.

However, when considering these data it should be noted that these are average survival rates. People’s individual circumstances should be taken into account when considering their chance of survival, which could range from zero to almost 100%, depending on the cause and circumstances of the arrest.
Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture. In many cases it may be followed by prolonged treatment in an intensive care unit (ICU), often including artificial ventilation. In the immediate post-CPR period most people require at least a brief period of observation and treatment in an ICU or a coronary care. There is also some risk that the person will be left with brain damage and resulting disability, especially if there is delay between cardiorespiratory arrest and the initiation of CPR. CPR attempts are unavoidably physical and potentially traumatic, as a result of which death may occur in a manner that neither the person affected nor people close to them would have wished.

Detailed assessment is crucial to determine whether the benefit of attempting CPR outweighs the risks and burdens for each individual.

3. STATEMENT OF INTENT

The policy is intended to ensure that appropriate attempts at CPR are undertaken, thus minimising distress to patients and their loved ones.

Implementation of the policy will lead to:

1. Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

2. Considering that cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.

3. For many people anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

4. Ensuring that every decision about CPR must be made on the basis of a careful assessment of each individual’s situation. These decisions should never be dictated by ‘blanket’ policies.

5. Each decision about CPR being subject to review based on the person’s individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person’s clinical progress or lack thereof.

6. Recognising triggers for review should include any request from the patient or those close to them, any substantial change in the patient’s clinical condition or prognosis and transfer of the patient to a different location (including transfer within a healthcare establishment).
7. Involving a person in whom CPR may be successful, when a decision about future CPR is being considered there should be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person’s wishes, feelings, beliefs and values in order to reach a ‘best interests’ decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision-makers.

8. Respecting that a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing treatment (ADRT), specifically refusing CPR, is upheld.

9. Recognising that if the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.

10. Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or of those close to the patient. However there is a presumption in favour of informing a patient of such a decision. The patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.

11. Effective communication: essential to ensure that decisions about CPR are made well and understood clearly by all those involved.

12. Clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them.

13. Decisions about CPR being communicated clearly to all those involved in the patient’s care.

14. Healthcare professionals, patients and those close to patients understanding that a decision not to attempt CPR applies only to CPR and not to any other element of care or treatment. A DNACPR decision must not be allowed to compromise high-quality delivery of any other aspect of care.

15. A DNACPR decision not overriding clinical judgement in the unlikely event of a reversible cause of the person’s respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include but are not restricted to: choking, a displaced tracheal tube or a blocked
tracheostomy tube.

16. Recognising that if a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

17. Decisions about CPR being from any discrimination, for example in respect of a disability. A best-interests decision about CPR is unique to each person and is to be guided by the quality of future life that individual would regard as acceptable.

18. Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific DNACPR.

19. A DNACPR in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient’s cardiorespiratory arrest or death. The final decision regarding whether or not to attempt CPR rests with the healthcare professionals responsible for the patient’s immediate care.

20. Use of a DNACPR that is used, recognised and accepted across Cumbria is a basic recommendation and may be paper-based or electronic.

21. Recorded decisions about CPR will accompany a patient when they move from one setting to another.

22. Records of decisions about CPR must be accurate and up-to-date. Systems (whether paper-based or electronic) for recording these decisions must be responsive and reliable, in particular, to any change in the decision about CPR.

23. Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

24. Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable,
especially when many would not have wanted CPR had their needs and wishes been explored.

25. Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and, where appropriate, explained to the patient and those close to the patient at the earliest practicable opportunity.

4 DEFINITIONS

| AAGBI Association of Anaesthetists of Great Britain and Ireland ADRT Advanced decision refusing treatment BMA British Medical Association CPR Card-pulmonary resuscitation DNACPR Do not attempt cardio-pulmonary resuscitation GMC General Medical Council GP General practitioner ICD Implantable cardioverter defibrillator ICU Intensive Care Unit IMCA Independent mental capacity advocate LPA Lasting power of attorney NCEPOD National Confidential Enquiry into Patient Outcomes and Death NMC Nursing and Midwifery Council NWAS North West Ambulance Service RCN Royal College of Nursing SRO Senior Resuscitation Officer

5 DUTIES

5.1 Trust Board

Responsibilities include:

- receiving regular reports from the Community Care Group
- Governance Committee
- receiving and discussing minutes from the Care Group
- Governance Committee

5.2 Clinical Governance Committee

Responsibilities include:

- receiving regular reports from the Resuscitation Committee
- receiving and discussing minutes from the Resuscitation Committee
5.3 Resuscitation Committee

Responsibilities include:

- ensuring that the audit process is occurring and reviewing the results with follow-up recommendations and action plan
- reviewing the Resuscitation Policies at least every 3 years and feeding back findings on the Resuscitation service to the Clinical Governance Committee

5.4 Clinicians

The person who makes a DNACPR decision must have the appropriate competency and be a recognised decision maker (recognised healthcare professional)

The clinician making the decision is responsible for ensuring that the decision is communicated effectively to other relevant health and social care professionals and all persons with parental responsibility in the case of a child. Clinicians MUST document on the DNACPR form the reason why a patient has not been informed of a DNACPR decision if a decision is made not to inform the patient. Clinicians may be asked to justify their decision.

5.5 Senior Nurse

The senior nurse is responsible for making sure the decision is recorded in the nursing notes if these are separate from the medical notes.

5.6 Resuscitation Officers

The Resuscitation Officers will audit compliance with the policy on an annual basis and report their findings to the Resuscitation Committee and Clinical Governance Committee.

6.1 DETAILS OF THE POLICY

6.2 DNACPR applies only to CPR

A decision not to attempt CPR applies only to CPR. All other appropriate treatment and care for that person should continue. It is important that this is widely understood by healthcare professionals and that it is made clear to patients and those close to them. This is essential as it is a common fear amongst members of the public that ‘DNACPR’ applies to all elements of treatment. Inclusion of decisions relating to CPR as part of an advance care plan or treatment escalation plan may help to emphasise which other treatment options are and are not appropriate for each individual, but quality of care should not be limited by any such plans or decisions.

Healthcare professionals should ensure that a DNACPR decision is not allowed to compromise the quality of care for any patient. To avoid confusion, the phrase
‘do not attempt cardiopulmonary resuscitation’ should be used, rather than ‘do not resuscitate’ or ‘do not attempt resuscitation’.

6.3 DNACPR decisions where CPR will not be successful and patients have capacity

In relation to decisions about CPR the courts have stated that there should be a presumption in favour of patient involvement and that there needs to be convincing reasons not to involve the patient.

In a judgment in the Court of Appeal the Master of the Rolls stated:

“In my view, doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardio-respiratory arrest. If however the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her. I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find that such decisions, if conscientiously taken, violate a patient’s rights under article 8 of the Convention.”

Whilst there should be a presumption in favour of informing patients of DNACPR decisions (made because CPR will not be successful) some people make it clear that they do not wish to talk about dying or to discuss their end-of-life care, including decisions relating to CPR. When such wishes are expressed they should be respected. It is poor practice to force discussions on patients who have stated clearly that they do not want them. Any such refusal should be documented clearly, together with a plan to ensure that optimal care of the patient is not compromised by that refusal.

In all other circumstances, when a clinical decision is made that CPR should not be attempted, because it will not be successful, careful consideration must be given as to whether or not to inform the patient. Although people should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases people should be informed, but for some, for example those who know that they are close to the end of their life, such information may be so distressing as to cause the person to suffer physical or psychological harm.
These decisions become even more challenging in the context of a severe, acute illness (or acute deterioration in a chronic condition), when the person affected has not considered or recorded their wishes regarding end-of-life care. Whilst the presumption in favour of patient involvement remains, there will be circumstances when giving information and explanations about CPR decisions at an early stage to a person who is seriously ill may cause harm. However, failure to make a timely DNACPR decision when CPR will not be successful will result in people receiving inappropriate CPR that they would not have wanted. Faced with such a situation clinicians should make the DNACPR decision that is needed and record fully their reasons for not explaining it to the patient at that time. Ensuring that there is on-going active review of the decision and of the patient’s ability to accept explanation of it without harm, so that the patient is informed at the earliest appropriate opportunity.

In any situation a clinician who makes a conscientious decision not to inform a patient of a DNACPR decision, as they believe that informing the patient is likely to cause them harm, should document clearly their reasons for reaching this decision. Other patients will indicate that they want detailed information about their care and want to be fully involved in planning for the end of their life. They may also want an opportunity to receive a second opinion should there be any disagreement.

Therefore a sensitive and skilled assessment should be made of how much information the individual person wants to know. The decision must be the one that is right for the patient, and information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team. In considering this, clinicians should take account of the fact that people are legally entitled to see and have a copy of their health records, or may be discharged home (e.g. from hospital or a hospice) with a DNACPR decision form. It may therefore be preferable for them to be informed of the existence of a DNACPR decision, and have it explained to them, rather than discover it by chance as this may be more distressing and may generate dissatisfaction or loss of trust. Where the patient has capacity, information regarding CPR should be provided to other people, including family members, only with the patient’s consent.

6.4 DNACPR decisions where CPR will not be successful and patients lack capacity

If the person lacks capacity and has appointed a welfare attorney whose authority extends to making decisions of this nature on their behalf, or if a court has appointed a deputy or guardian with similar authority to act on the individual's behalf, this attorney, deputy or guardian must be informed of the decision and the reason for it. If the welfare attorney does not accept the decision, a second opinion should be offered, whenever possible.

When a person lacks capacity and a decision is made that CPR will not be attempted because it will not be successful, it is good practice to ensure (subject to any confidentiality restrictions expressed when the patient had
capacity) that those close to patients are informed of this decision and of the reasons for it. Sensitive and careful explanation is often needed to help people to understand that the intention is to spare the patient traumatic and undignified treatment that will be of no benefit, as they are dying, not to withhold life-saving treatment, and not to withhold any other care or treatment that they need.

When a DNACPR decision is needed in the setting of an acute, severe illness with no realistic prospect of recovery it is important that the decision is not delayed (and the quality of care for the patient compromised thereby) if the patient's family members or other carers are not available immediately to have the decision explained to them. A timely decision must be made in the interests of delivering high-quality care, and that decision and the reasons for making it must be documented fully. The decision should then be explained to those close to the patient at the earliest opportunity.

6.5 Requests for CPR in situations where it will not be successful

Patients have no legal right to treatment that is clinically inappropriate. Sometimes patients or those close to them will try to demand CPR in a situation where it is clinically inappropriate. If the healthcare team has good reason to believe that CPR will not re-start the heart and breathing, this should be explained to the patient in a sensitive but unambiguous way. These decisions, and the subsequent discussions informing the patient of the healthcare team’s decision, can be difficult. They should be undertaken by clinicians with the relevant training and expertise, both in assessing the likely outcome and appropriateness of CPR, and with the relevant communication skills. If the patient does not accept the decision a second opinion should be offered, whenever possible. Similarly, if those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation, a second opinion should be offered. The courts have confirmed that there is no legal obligation to offer to arrange a second opinion in cases where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate.

6.6 Communicating DNACPR decisions where CPR will not be successful

Communicating DNACPR decisions can be particularly challenging for healthcare Professionals. However, failure to explain clearly to patients or those close to them that a DNACPR decision has been made, and the basis for it, can lead to misunderstanding, potentially avoidable distress and dissatisfaction, and in some instances, complaint or litigation. As with any other aspect of care, healthcare professionals must be able to justify their decisions.

Sensitive communication about CPR decisions should be undertaken by professionals with training and expertise in having those discussions. Whilst the most senior healthcare professional caring for the patient carries the ultimate responsibility for a decision about CPR, there may be situations in which another member of the healthcare team is best placed to discuss and
explain it to the patient or those close to the patient.

In most cases it is helpful to support full verbal discussion of such decisions with printed information. Healthcare professionals discussing and communicating CPR decisions to patients, and those close to them, will:

• offer as much information as wanted (with due regard for the patient’s wishes concerning confidentiality)
• be open and honest
• use clear, unambiguous language
• use a combination of verbal discussion and printed information
• provide information in formats which people can understand; this may include the need for an interpreter or easy-to-read formats
• provide information that is accurate and consistent
• check understanding
• where possible, communicate decisions in an appropriate environment and allow adequate time for discussion and reflection

6.7 Decisions about CPR that are based on a balance of benefits and burdens

If CPR may be successful in re-starting the person’s heart and breathing for a sustained period, the potential benefits of prolonging life must be balanced against the potential harms and burdens of CPR. This is not solely a clinical decision. For the patient with capacity there should be open dialogue and shared decision-making between the patient and professionals, unless the patient declines any such discussion. For the patient who lacks capacity the requirements for an assessment and decision based on their best interests should be followed.

People should be informed sensitively about what CPR involves and it's possible risks and adverse effects, as well as its likely chance of success in their specific circumstance, to try to help them to make informed decisions about whether or not they would want it. In addition to the possible clinical effects of CPR, the information needed may include, for example, a hospice patient being informed that there is a risk that they may be transferred to an acute hospital setting for post-resuscitation care for which the hospice does not have facilities. Many people (including patients, those close to them and even some healthcare professionals) have unrealistic expectations about the likely success and potential benefits of CPR and members of the public often lack detailed understanding of what is involved. The picture gained from the media (television drama for example) seldom reflects a realistic view of the success rate, or the physical nature of CPR. News reports have tended to describe CPR as 'life-saving treatment' without reference to those for whom it will offer no benefit or for whom it may be more likely to cause burden than benefit. While healthcare professionals, understandably, are reluctant to alarm people or deter them from treatment which may be life-prolonging, it is important that everybody contributing to decisions about CPR is aware of what
is involved and of the factors that may affect the outcome. Some patients or those close to them may struggle to understand why a decision about CPR is relevant, if the person is not known to have a specific problem with their heart or breathing. Careful explanation will be needed to help them to understand that:

- cardio-respiratory arrest is part of the final stage of dying
- CPR is unlikely to be successful when someone is dying from an advanced and irreversible or incurable illness
- health care professionals may start CPR inappropriately when someone dies unless a DNACPR decision has been made and recorded.

Prolonging life is not always beneficial. The courts have confirmed that it is lawful to refrain from an attempt at CPR on the basis that it would not be in the person’s best interests.

In assessing the potential benefits of attempting to prolong life, it is important to consider whether cardiorespiratory arrest is likely to recur and whether the person is likely to experience unmanageable or long-term pain or other distressing adverse effects. Some patients may, despite potentially distressing adverse effects, have specific reasons for wanting to try to delay death, even if this is only for a short period of time. If such a wish is expressed, accurate information must be provided about the realistic likelihood, length and quality of survival that might be expected, and about the potential harms and burdens of attempted CPR. The patient should be invited to discuss the risks and benefits of CPR in order to reach an agreed decision on whether or not it should be attempted. Nevertheless, a clinician cannot be forced to perform any intervention that she or he considers to be harmful or against a person’s interests.

Balancing benefits against harms and burdens in these cases also involves balancing rights under the Human Rights Act 1998. The Act guarantees protection for life (Article 2) but also declares that “no one shall be subjected to torture or to inhuman or degrading treatment or punishment” (Article 3). This terminology is intended to apply to situations in which people are deliberately ill-treated or have severe indignities inflicted upon them. However, some people do not wish to be kept alive in a state of total dependency or permanent lack of awareness, or to have an undignified death. If people express such views, healthcare professionals should take these into account when decisions about CPR are being considered. They should not attempt to prolong life if it is clear that the person would not want this or would consider the likely outcome unacceptable. The duty to protect life must be balanced with the obligation not to subject the person to treatment that they would regard as inhuman or degrading.

A decision that CPR will not be attempted, because the risks outweigh the benefits, should be made only after careful consideration of all factors relevant to the patient’s current situation, and after discussion with the patient (unless they refuse such discussion) or with those close to patients
who lack capacity. These factors include:

- the likelihood of re-starting the person’s heart and breathing for a sustained period.
- the level of recovery that can be expected realistically after successful CPR.
- the person’s known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values of those who lack capacity.
- the person’s human rights, including the right to life, the right to be free from degrading treatment, which may include a dignified death, and the right to respect for a private and family life.
- the likelihood of the person experiencing continuing pain or suffering that they would find intolerable or unacceptable.
- the level of awareness the person has of their existence and surroundings.
- The fact that a decision has been made to attempt CPR in the event of cardiorespiratory arrest does not mean that all other intensive treatments and procedures will also be appropriate. For example, prolonged support for multi-organ failure (e.g. artificial ventilation, renal dialysis or hemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump) in an ICU may be clinically inappropriate if the patient is unlikely to survive these other treatments, even though the heart has been re-started. Conversely some people may have a DNACPR decision in place but it may still be clinically appropriate for them to be admitted to an ICU for other treatment – for example, for hemofiltration.

After resuscitation from cardiac arrest most people will require at least a brief period of monitoring, observation and treatment in a cardiac care unit or ICU. When discussing the benefits and risks of CPR with people, it is important to ensure that this is understood. For some people it will be important to take into account the possibly reduced likelihood of benefit from CPR in those for whom organ support in an ICU would not be clinically appropriate, and through sensitive discussion to help people to understand this. However, ineligibility for multi-organ ICU support is not, in itself, justification for an automatic DNACPR decision.

6.8 ‘Restricted’ CPR attempts

Another difficult subject is the question of whether it is appropriate to make a decision to restrict the type or extent of CPR that is to be applied in specific
circumstances. This policy advocate that people should be considered either ‘for CPR’ or ‘not for CPR’ and that there should be no ‘half-measures’. Clearly, if CPR is to be attempted, it should be performed competently. It is inappropriate to initiate resuscitation and then not try hard to achieve a successful outcome.

6.9 Requests for CPR where the harms and burden may outweigh the benefits

Some patients ask for CPR to be attempted, even if the clinical evidence suggests that the harms and burdens are likely to outweigh the possible benefit. Although the healthcare team may doubt whether the risks associated with CPR are justified by a very small chance of success, the individual whose life is at stake may be willing to accept that chance. Realistic information must be provided sensitively to people about the nature of CPR and the likely risks, including the risk of long-term neurological damage, but if patients still ask that no DNACPR decision be made, this should usually be respected.

If they subsequently suffer cardiac or respiratory arrest, further clinical decisions must be made in accordance with the advice in this guidance, taking account of both the clinical situation at the time and the patient’s wishes. These difficult situations are a potential source of confusion. Doctors cannot be required to give treatment that is contrary to their clinical judgement, but should be willing to consider and discuss people’s wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where attempted CPR has a reasonable chance of successfully re-starting the heart and breathing for a sustained period, and a person has decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. In the unusual circumstance in which the doctor responsible for a patient’s care feels unable to agree to their expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, a second opinion should be sought.

Transfer of the patient’s care to another doctor or team can be considered if there is still a lack of agreement and it is feasible.

6.10 Communication and discussion with patients with capacity

When a person with capacity is at foreseeable risk of cardiac or respiratory arrest, they should be offered information about CPR, about the local resuscitation policy and services, and about their role in decision-making in relation to CPR. In order to determine whether the benefits of CPR would be likely to outweigh the harms and burdens, or whether the level of recovery expected would be acceptable to the patient, there should be sensitive exploration of the patient’s wishes, feelings, beliefs and values.

People with capacity should be given opportunities to talk about CPR, but information and discussion should not be forced on unwilling patients. If people indicate that they do not wish to discuss CPR this should be
respected and documented.

If a best-interests decision about CPR is made by the healthcare team because the patient declined discussion about CPR or asked the healthcare team to make a decision for them, this must be documented in the health record, together with the basis for the decision. As with any other aspect of care, healthcare professionals must be able to justify their decisions.

6.11 Communication and discussion with those close to patients who lack capacity

If a person lacks capacity, any previously expressed wishes should be considered when making a CPR decision, bearing in mind that in some cases those wishes may relate to circumstances that differ substantially from the present situation, or from the circumstances of a future cardiorespiratory arrest. Whether the benefit would outweigh the harms and burdens for a particular patient should be the subject of discussion and agreement between the healthcare team and those close to or representing the patient. Relevant information should be shared with those close to patients unless, when they were previously competent to do so, a patient has expressed a wish that information be withheld.

Consulting with those close to patients in these circumstances is not only good practice but is also a requirement of the Human Rights Act (Articles 8 – right to private and family life and 10 – right to impart and receive information), and is ordinarily a requirement of the Mental Capacity Act 2005 (England and Wales). The NHS Constitution for England also notes that people have the right to be involved in discussions and decisions about their health and care, including their end-of-life care, and to be given information to enable them to do this. Where appropriate this right includes their family and carers.

Clinicians should ensure that those close to the patient, who have no legal authority to make decisions for the patient, understand that their role is to help inform the decision-making process, rather than being the final decision-makers. Great care must be taken when people other than the patient make or guide decisions that involve an element of quality-of-life assessment, because there is a risk that healthcare professionals or those close to the patient may see things from their own perspective and allow their own views and wishes to influence their decision, rather than those of the patient. These considerations should always be undertaken from the patient’s perspective. An important factor is whether the patient (if they had capacity) would regard the level of possible recovery acceptable, taking into account the invasiveness of CPR and its likelihood of success in the individual circumstances under consideration, not whether it would be acceptable to the healthcare team or to those close to the patient, nor what they would want if they were in the patient’s position.
6.11. Circumstances when a CPR decision may not be followed

There are circumstances in which a CPR decision has been documented in advance, but when the patient suffers cardiorespiratory arrest the attending healthcare professionals assess the situation and make a decision to act contrary to the previously documented decision. See below.

6.12 Contemporaneous clinical assessment

Unless there is a valid and applicable advance decision (ADRT) refusing CPR, a DNACPR form is not binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient’s death or cardiorespiratory arrest. The final decision regarding the application or not of the CPR decision in an emergency rests with the healthcare professionals responsible for managing the patient’s immediate situation.

The healthcare professional may, on attending an arrest, make a clinical assessment resulting in a different decision to the one on the DNACPR form. As with any clinical decisions, healthcare professionals must be able to justify their decision. In particular, clinicians should be cautious of overriding a DNACPR decision where the DNACPR form records that the patient has expressed a clear wish not to receive attempted CPR.

6.13 Not the envisaged circumstances

Occasionally, some people for whom a DNACPR decision has been made may develop cardiac or respiratory arrest from a readily reversible cause such as choking, a displaced or blocked tracheal tube, or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the person has made a valid refusal of the intervention in these circumstances.

To avoid misunderstandings it may be helpful, whenever possible, to make clear to patients and those close to patients that DNACPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest and not to an unforeseen event such as a blocked airway.

6.14 Temporary suspension

In addition to readily reversible causes, it may be appropriate to suspend a decision not to attempt CPR temporarily during some procedures, if the procedure itself could precipitate a cardiorespiratory arrest, especially if there is a high probability that prompt treatment of the arrest may be effective. For example, cardiac catheterisation, pacemaker insertion, or surgical operations may occasionally trigger cardiorespiratory arrest. General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment, which may include CPR.
Under these circumstances, where a cardiorespiratory arrest and its cause can be treated promptly, survival rates are much higher than those following many other causes of in-hospital cardiac arrest. DNACPR decisions should be reviewed in advance of the procedure. This should be discussed with the patient or their representative if they lack capacity, as part of the process of seeking informed consent for the procedure. Some patients may wish a DNACPR decision to remain valid despite the risk of a cardiorespiratory arrest from a reversible cause; others will request that the DNACPR decision is suspended temporarily. The time at which the DNACPR decision is reinstated should also be discussed, agreed in advance and documented.

If a patient wants a DNACPR decision to remain valid during a procedure or treatment that carries some risk of cardiorespiratory arrest this may increase the mortality risk of the procedure or treatment. As an extreme example, some cardiac surgical procedures require induction of cardiac arrest as a necessary part of the procedure, so treatment could not be completed successfully without reversal of that arrest by defibrillation. If a clinician believes that a procedure or treatment would not be successful or would be unacceptably hazardous with the DNACPR decision still in place, it would be reasonable not to proceed.

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) have published specific guidance on management of DNACPR decisions in the perioperative period. In the event of disagreement the patient should be offered a second opinion.

6.15. Initial presumption in favour of CPR when there is no recorded CPR decision

If no explicit decision has been made in advance about CPR and the express wishes of a person are unknown and cannot be ascertained, there should be an initial presumption that healthcare professionals will make all reasonable efforts to resuscitate the person in the event of cardiac or respiratory arrest. In such emergencies there will rarely be time to make a comprehensive assessment of the person’s condition and the likely outcome of CPR. In these circumstances initiating CPR will usually be appropriate, whilst all possible efforts are made to obtain more information that may guide further decision-making. Healthcare provider organisations and healthcare professionals should support anyone initiating and delivering CPR in such circumstances.

There will be some situations in which CPR is started on this basis, but during the resuscitation attempt further information becomes available that makes CPR inappropriate. That information may include a fully documented DNACPR decision, a valid and applicable advance decision to refuse treatment (ADRT), or clinical information indicating that CPR will not be successful. In such circumstances, continuing attempted resuscitation would be inappropriate.

There will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom
no formal DNACPR decision has been made. Also, there will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional that makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies.

6.16. Refusals of CPR by adults with capacity

Clearly people will lack capacity at the time of suffering cardiac or respiratory arrest, but anticipation of a possible arrest may enable them to decide in advance whether or not they want CPR to be attempted. It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where healthcare teams believe that CPR may be successful in re-starting a person’s heart and breathing for a sustained period, discussion should take place with that person to determine their views and wishes regarding CPR. If people decide that they do not wish to have CPR attempted, this should be documented clearly in their health records (whether hospital, general practitioner (GP) or healthcare establishment’s records) and steps should be taken to ensure that this is communicated to those who need to know (see section 16).

People are not obliged to justify their decisions about their future treatment, but healthcare professionals usually wish to discuss the implications of a refusal of treatment with people in order to ensure that the decision is based on accurate information and not on any misunderstanding; however they must take care not to pressure people into accepting treatment that they do not want. Some people may be content for their refusal of CPR simply to be documented in their health record but they should be informed that if they want the refusal to be binding, in England and Wales, they should make a formal ADRT following the criteria stipulated in the Mental Capacity Act 2005 (England and Wales).

6.17 Advance decisions refusing CPR

CPR must not be attempted if it is contrary to a valid and applicable ADRT (sometimes referred to as a ‘living will’) made when the person had capacity (see below for criteria for validity).

Advance decisions are covered by the Mental Capacity Act 2005. The Act confirms that an ADRT refusing CPR will be valid, and therefore legally binding on the healthcare team, if:

- the person was 18 years old or over and had capacity when the decision was made
- the decision is in writing, signed and witnessed
- it includes a statement that the advance decision is to apply even if the person’s life is at risk
- the advance decision has not been withdrawn
- the person has not, since the advance decision was made,
appointed a welfare attorney to make decisions about CPR on their behalf

- the person has not done anything clearly inconsistent with its terms
- the circumstances that have arisen match those envisaged in the advance decision.

If an ADRT does not meet these criteria but appears to set out a clear indication of the person's wishes, it will not be legally binding but should be taken into consideration in determining the person's best interests. A number of examples of ADRTs can be found in the public domain.

Some people have tried to maximise the likelihood that their wishes are respected by having a tattoo, usually on their chest, with the words 'Do not resuscitate' or similar. On its own it does not constitute a legally binding ADRT but should be taken into consideration when assessing a person's previously expressed views and wishes, in order to make a decision in their best interests. Where a person has taken such a measure, and where this is regarded as a fully informed decision by a person with capacity, that person should be encouraged to make a formal, written ADRT in addition.

6.18 Assessing validity and applicability

Although an ADRT may not come to light until a person has lost capacity, there should be a presumption that the person had capacity when an advance decision was made, unless there are grounds to suspect otherwise. The onus is on patients to ensure that healthcare teams will be made aware of the existence and content of any ADRT. Ensuring that their family and others close to them are fully aware of the existence and location of the ADRT document will help to maximise the likelihood that their instructions are followed.

Healthcare professionals must decide whether the ADRT is applicable to the circumstances that have arisen. Particular care will be needed where an ADRT has not been reviewed or updated for a long time and attention should be given to any relevant clinical developments or changes in the person's personal circumstances since the decision was made. For example, some people may have taken actions or made other important decisions that indicate that they had changed their mind.

Where there is genuine doubt about the validity and applicability of an ADRT (and when time permits) further enquiries should be made and, if necessary, an application made to the Court of Protection for a judgment. In an emergency, where there is no time to investigate further, the presumption should be in favour of CPR if this has a realistic chance of prolonging life. If it is agreed that an ADRT is invalid or not applicable the reasons should be documented.
6.19 Adults who lack capacity

This section explains who should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales) concerning proxy decision-makers. Decision-making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast, to decisions about serious medical treatment, for example CPR. Adults should be assumed to have capacity unless there is clear evidence to the contrary. A person is regarded as legally unable to make a decision for themselves if they are unable to do any of the following:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision, or
- communicate their decision (whether by talking, using sign language, visual aids or by other means).

More detailed guidance on mental capacity legislation, including when to make formal capacity assessments can be found on the British Medical Association(BMA) website at www.bma.org.uk/ethics

6.20 Adults who lack capacity and have (i) not appointed a welfare attorney or other legal surrogate or (ii) not made an advance decision refusing CPR – but do have family and/or friends

Where a patient has not appointed a welfare attorney or made an advance decision, the treatment decision rests with the most senior clinician responsible for the patient’s care. Where CPR may re-start the patient’s heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient’s best interests. In order to assess best interests, where possible the views of those close to the patient must be sought, to determine any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR. In reaching a decision:

The Mental Capacity Act requires that best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, and anyone engaged in caring for the person or interested in the patient’s welfare. Under the Act, all healthcare professionals must act in the best interests of a patient who lacks capacity.

In these circumstances, it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient, but to help the healthcare team to make an appropriate decision in the patient’s best interests. Relatives and others close to the patient should be assured
that their views on what the patient would want will be taken into account in
decision-making but that they cannot insist on a treatment or on withholding
or withdrawal of a treatment.

It is important that a decision about CPR is not delayed inappropriately (and
the quality of care for the patient compromised thereby) if the patient’s
family members or other carers are not available immediately to discuss a
best-interests decision or to have a DNACPR decision explained to them
where CPR would not be successful. In that situation the senior healthcare
professional responsible for the patient’s care should make and document
the decision, and ensure that those close to the patient are consulted
and/or have the decision explained to them at the earliest opportunity.

6.21 People with a welfare attorney or court-appointed deputy or
guardian

If people lack capacity and have a welfare attorney or guardian, this person
must be consulted about CPR decisions that are made on a balance of
benefits and risks. However, if CPR would not be successful, welfare
attorneys and guardians should be informed of the resulting DNACPR
decision and the reasons for making it.

The Mental Capacity Act allows people over 18 years of age who have
capacity to give Lasting Power of Attorney (LPA), appointing a Welfare
Attorney to make health and personal welfare decisions on their behalf
once such capacity is lost. The Court of Protection may, on application,
appoint a deputy with similar powers.

Before relying on the authority of this person, the healthcare team must
be satisfied that:

- the patient lacks capacity to make the decision for him or herself
- a statement has been included in the LPA specifically
  authorising the welfare attorney to make decisions relating to
  life-prolonging treatment
- the LPA has been registered with the Office of the Public
  Guardian
- the decision being made by the attorney is in the patient’s
  best interests

Neither welfare attorneys nor deputies can demand treatment that is
clinically inappropriate. Where CPR may be able to re-start the heart and
breathing for a sustained period and a decision on whether or not to
attempt CPR is based on the balance of benefits and risks, views of the
attorney or deputy about a patient’s best interests must be sought. Where
there is disagreement between the healthcare team and an appointed
welfare attorney or court-appointed deputy about whether CPR should be
attempted in the event of cardiorespiratory arrest, and this cannot be
resolved through discussion and a second clinical opinion, the Court of
Protection may be asked to make a declaration.

More information about welfare attorneys, deputys and the Mental Capacity Act can be found in the Mental Capacity Act code of practice.

6.22 Adults who lack capacity and have no family, friends or other advocate who it is appropriate to consult

In England and Wales, the Mental Capacity Act 2005 requires consultation with an independent mental capacity advocate (IMCA) regarding all decisions made by an NHS body or Local Authority about ‘serious medical treatment’, where people lack capacity and have nobody to speak on their behalf. The definition of serious medical treatment includes circumstances where “what is proposed would be likely to involve serious consequence for the patient”. It can be argued that a decision not to attempt CPR because it will not work will not have ‘serious consequences’ for the patient, because the patient will die with or without attempting CPR. For this reason, in our view, it is not necessary to consult an IMCA when it is clear to the medical team that CPR would not re-start the patient’s heart and breathing for a sustained period. Nevertheless, neither the Act, nor the code of practice, differentiates between decisions made purely on clinical grounds (i.e. because the treatment is unable to achieve its clinical aim) and those that involve broader best-interests considerations and so it should be acknowledged that there is still some uncertainty in this area.

Where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a decision about CPR is being considered on the balance of benefits and risks, in order to comply with the law an IMCA must be involved in every case. If a CPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and the reasons for it should be recorded in the health record and an IMCA should be consulted at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician responsible for the person’s care as part of the determination of that person’s best interests.

6.23. Children and young people under 18 years of age

Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, parents and the healthcare team. As with adults, decisions about CPR must be made on the basis of an individual assessment of each child or young person’s current situation. It is not necessary to initiate discussion about CPR if there is no reason to believe that the child is likely to suffer a cardiorespiratory arrest. If CPR will not re-start the heart and breathing, it should not be attempted. Often these decisions are made in the context of a wider decision-making framework.

The refusal of treatment by competent young people up to the age of 18 is not
necessarily binding upon doctors. The courts have overridden competent young people’s refusal of life-saving treatment in the past. Where a young person who is competent refuses treatment, the potential harm caused by violating the young person’s choice must be balanced against the risk from not giving treatment – in the case of CPR, this will result in a missed opportunity to try to save the life of the young person.

As noted above, a young person’s refusal is not necessarily binding but young people who are competent to do so are entitled to give consent to medical treatment. Where they are not competent it is generally those with parental responsibility who make decisions on their behalf. Young people 16 years of age and over are assumed to be competent to consent to medical treatment unless there is evidence to the contrary. Young people under the age of 16 can also be assessed to be competent to consent to medical treatment. Competent children and young people who are under the age of 16 are sometimes referred to as being ‘Gillick competent’.

Mental capacity legislation also applies to young people aged 16 and over who lack capacity with some exceptions. For example, they cannot make Advance Decisions to Refuse Treatment (ADRTs) or Lasting Powers of Attorney (LPAs) under the legislation in England.

6.24. Confidentiality

If adults have capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing information with others, including family and friends. It may also be helpful to ask people with capacity who they want, or do not want, to be involved in decision-making if they become incapacitated (although it should be made clear that unless this person is formally appointed as a welfare attorney their role will be limited to providing information for the healthcare professional who decides about treatment). Refusal by a person with capacity to allow information to be disclosed to family or friends must be respected. Whilst this may present difficulties in discussing care with people close to the patient, healthcare professionals should explain, with due sensitivity and empathy, their duty of confidentiality to the patient and that disclosure of information has been limited explicitly by the patient.

Where people lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to those close to the patient where this is necessary to discuss the patient’s care and is not contrary to the patient’s interests. Even where their views have no legal status in terms of actual decision-making, it is good practice to involve people close to patients in discussions that inform decisions. Where there is a welfare attorney, deputy, or guardian involved in the discussions, relevant information should be provided to them to enable them to fulfil their role. Where an IMCA is involved they have a legal right to information, including access to the relevant parts of the patient’s health records, in order to enable them to carry out their statutory role.
In general children and young people are content for their parents to be involved in their care; however, the same principles of confidentiality for adults apply also to all children and young people. If a child or young person is reticent to involve his or her parents every reasonable effort must be made to persuade the child to involve parents or guardians, particularly for important or life-changing decisions. Where the child is not competent and does not want parental involvement, The General Medical Council (GMC) advises that where “it is necessary in the child’s best interests for the information to be shared (for example, to enable a parent to make an important decision, or to provide proper care for the child), you can disclose information to parents or appropriate authorities”.

6.25. Provision of information in printed and other formats for patients and those close to patients

Although printed information should never be used as a substitute for clear and full verbal discussion and provision of information, printed information should be used as well, both to raise people’s awareness of the importance of decisions about CPR and to supplement or reinforce information provided in discussion. Healthcare organisations (including hospitals, hospices, general practices, ambulance services and care homes) should include information about their CPR policies, in the general literature provided to patients and the public. Those policies, whilst primarily intended to direct staff, should also be accessible by patients and the public, should they wish to examine them. In addition specific information about CPR and about decisions relating to CPR should be readily available and offered in printed format to patients at foreseeable risk of dying or suffering sudden cardiorespiratory arrest, to those close to them when appropriate and to others who express a wish to know more about or discuss CPR. The BMA, Resuscitation Council (UK) and Royal College of Nursing (RCN) have produced a model information leaflet, addressing some of the common questions that people ask, or may want to ask. It should be amended to include local information, and is available on the websites of the three organisations.

Some organisations may wish to provide information in additional ways, for example using a digital video recording. These should be regarded as supplementary to and not a substitute for verbal and printed information.

Provision of information should aim to de-mystify the process by which CPR decisions are made.

It should make clear that, although for many people the need to make a decision about CPR will not arise, for many others discussion of their wishes regarding CPR is a routine and important part of providing them with high-quality care. Information should explain to people their part in decision-making, what facilities are available, and in general terms what situations it is likely that CPR may be or will not be successful.
6.26. Responsibility for decision-making

The overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician currently responsible for the person’s care as defined explicitly by local policy.

This could be a medical practitioner either at consultant, general practitioner or other medical grade, but equally it could be an approved nurse or other healthcare professional who has the appropriate clinical knowledge and expertise to make such decisions and who has been specifically approved by the Care Group Management Team within which he or she works. The responsible clinician should always be prepared to discuss a CPR decision with other healthcare professionals involved in the person’s care and wherever possible and appropriate, a decision about CPR should be agreed with the whole healthcare team.

Teamwork and good communication are of crucial importance in the delivery of high-quality care. If there is doubt or disagreement about the most appropriate decision, a second opinion should be sought. The GMC advises that “a second opinion should be from a senior clinician with experience of the patient’s condition but who is not directly involved in the patient’s care. It should be based on an examination of the patient by the clinician”. Where a DNACPR decision is made on clinical grounds, because there is no realistic chance that CPR will be successful, there is no legal obligation to offer a second opinion, especially in cases where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate.

Nevertheless, if the patient or those close to a patient do not accept a DNACPR decision a second opinion should be offered, where possible, in the course of good clinical practice.

Where care is shared, for example between hospital and general practice, or between general practice and a care home, the healthcare professionals involved should discuss a decision about CPR with each other and with other members of the healthcare team. There should be shared responsibility for deciding about the likelihood of a successful outcome from CPR, and discussing the subject with the patient or with those close to patients who lack capacity where appropriate. Nevertheless, one individual must take charge of ensuring that the decision is made properly, is recorded properly and communicated to all those who need to know it, including locum staff.

Unless the CPR decision form documents a valid ADRT for the circumstances encountered by the attending team, a CPR decision form is not legally binding and should be regarded as a clinical assessment, recorded to try to guide immediate clinical decision-making in the event of a patient’s death or cardiorespiratory arrest. The final decision regarding the application of the CPR decision in an emergency rests with the healthcare professionals dealing with the patient in the immediate situation.
6.27. Recording decisions

Any decision about whether or not to attempt CPR must be recorded clearly in the patient’s current health record, and should be available immediately and easily to all healthcare professionals who may need to know it, including staff of hospitals, hospices and nursing homes, GPs and other community healthcare professionals, out-of-hours medical services, and ambulance clinicians.

The DNACPR form itself should contain sufficient detail to allow a healthcare professional facing an emergency situation to assess quickly and easily the basis on which the decision was made, the people involved in making the decision (including the patient and if not, reasons why not), and others who have been informed of the decision. In many circumstances it is necessary to record additional information in the text of the patient’s health record. When a DNACPR form is transferred with a patient, this fact should be documented in the health record and include:

- the decision, including date and time
- detailed reasons for making the decision
- name and position of the person making the decision
- name and position of the person recording the decision
- if that is not the senior responsible clinician, the name and position of the senior responsible clinician, who should review and if appropriate endorse the decision at the earliest opportunity
- details of any discussions about the decision with the patient and with those close to them, and (for a person who does not have capacity) with any person with authority to make decisions on their behalf and/ or with an IMCA
- where no discussions have taken place the reasons for this
- what information was offered to the patient and those close to them
- members of the healthcare team who contributed to the decision
- if a second opinion was requested, details of that request and of the response
- details of any legal advice sought
- a formal assessment of the patient’s capacity, where necessary
- the existence and identity or the absence of an individual with legal authority to make decisions for a person who lacks capacity.

The DNACPR form should not be copied, to avoid the possibility that inappropriate clinical decisions or actions result from a copy of a form that relates to a decision that has been cancelled.
6.28 Electronic records

Increasingly, people (in particular those receiving end-of-life care) may have CPR decisions recorded electronically in a central database that is accessible by various healthcare providers. This may include ambulance services, out-of-hours services, general practices, hospitals and others. Where such databases are used, there is a possibility that a healthcare professional responding to an emergency may be told of the existence of a CPR decision or of an ADRT, but may not be able to see the content of those documents to check their validity.

Where such databases are used they should be accompanied by a clear policy on what action is to be taken when personal access to the documents is impossible. Wherever possible, such databases should have arrangements in place for relevant documents to be accessed electronically in an emergency situation.

Decisions relating to CPR must be documented fully and clearly in both electronic and paper records. Healthcare providers using electronic records should have systems in place to ensure that decisions relating to CPR are available as soon as they are required. The format and content of an electronic DNACPR form should be similar to that of a paper DNACPR form.

6.29 Co-signing of CPR decision forms

In the past, in some paediatric settings, parents have been asked to sign DNACPR forms. This is not advisable and can cause unnecessary additional distress.

Some healthcare professionals have suggested that adult patients should sign DNACPR forms, in a similar way that patients provide signed consent to treatment, such as an operation. This is not a legal requirement. Such a policy could be an obstacle to effective end-of-life care for some dying patients for whom discussions about CPR decisions will be potentially harmful and unnecessary.

There is no requirement for those close to patients to sign forms to confirm their agreement with/to a DNACPR decision. Asking them to do so could contribute to them inferring incorrectly that they are being asked to make the decision. It is common for those close to patients to misinterpret or forget precise detail of what they are told at such times, when they are understandably anxious and often tired. For this reason it is crucial that healthcare professionals document details of such discussions and explanations clearly in the patient’s health records.
6.30. Communicating decisions to other healthcare providers

The healthcare professional responsible for a CPR decision is also responsible for ensuring that the decision is communicated effectively to other relevant healthcare professionals in both primary and secondary care, including ambulance clinicians and staff of residential and nursing homes. The task of disseminating information may be delegated to another member of the healthcare team, but it should be clear who has responsibility for ensuring that this task is being undertaken effectively. The senior nurse is responsible for ensuring that every CPR decision is recorded in the nursing records (where the institution has separate nursing records), that those records are updated should the decision change and that all those nursing the patient are aware of the current decision.

6.31 Patient transfer

Any decision about CPR should be communicated between healthcare professionals whenever a patient is transferred between establishments, between different areas or departments of one establishment, or is discharged home from a healthcare establishment.

The General Medical Council (GMC) places a professional obligation on doctors to follow agreed systems and ensure good communication:

“You should check the handover arrangements where you work, and use the available systems and arrangements for information storage and exchange, to ensure that the agreed care plan is shared within the healthcare team, with both paid and unpaid carers outside the team and with other healthcare professionals involved in providing the patient’s care.

This is particularly important when patients move across different care settings (hospital, ambulance, care home) and during any out-of-hours period. Failure to communicate some or all relevant information can lead to inappropriate treatment being given (for example, DNACPR decisions not being known about) and failure to meet the patient’s needs (for example, their wish to remain at home not being taken into account).”

The Nursing and Midwifery Council (NMC) places a professional obligation on nurses and midwives:

“You must keep your colleagues informed when you are sharing the care of others.” And “You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care.”

There are many examples – at local, regional and national levels – of ways of ensuring that decisions are disseminated to all those involved in the care of patients.
For example, as noted in the previous section, agreeing standard DNACPR forms that are recognised locally, regionally or nationally by all healthcare establishments, the police, out-of-hours service providers, and ambulance service. These forms may be transferred with the patient or held (usually electronically) in an agreed central location.

Where a CPR decision has been recorded on a paper form (Deciding Right v.17) that is recognised and accepted by other healthcare providers it is recommended that the form travels with the patient, to ensure continuity. However this requires particular care to make certain that the patient is aware of and understands and accepts the continuing CPR decision and the reasons for it.

CPFT currently use the Deciding Rights DNACPR v.17 form. Where a patient coming into CPFT care has a CPR decision that has been recorded on a form other than the Deciding Rights v.17, that form should be considered active and valid at the time of admission, but steps must be taken for a reassessment of the CPR status at the earliest opportunity by the Senior Clinician responsible for that patient’s continuing care.

As emphasised in previous sections, decisions relating to CPR are best made as shared decisions between patients and their healthcare professionals whenever possible and appropriate. However some patients may forget previous discussions and agreements, particularly if they have been very unwell or there has been a long period between the decision and the time of transfer. In some clinical settings discussion of the decision may have been impossible or inappropriate due to the person’s health at the time of the decision, or may have been declined by the patient. In many circumstances involving the patient in the decision-making process through discussion or explanation is required under Article 8 of the Human Rights Act. Sensitive explanation to a patient of a CPR decision and of the form on which it is recorded is usually better than the patient discovering the decision by chance. The transfer of a DNACPR form with a patient greatly increases the importance of this. Prior to transfer, where appropriate, the continued relevance of a CPR decision and the reason for transfer with them of a DNACPR form should be discussed with and explained to patients.

6.32 Ambulance clinicians (North West Ambulance Service) NWAS

Problems have arisen previously when transferring patients between different settings because CPR decisions were not communicated or were not accepted as valid by the ambulance service or by the receiving organisation. Clinical guidelines issued by the Association of Ambulance Chief Executives advise ambulance clinicians that in the presence of cardiopulmonary arrest they should always initiate CPR unless the patient has a condition unequivocally associated with death, specifically massive cranial and cerebral destruction, hemicorporectomy or similar massive
injury, rigor mortis, hypostasis, decomposition/ putrefaction or incineration.

The ambulance service guidelines state also that resuscitation can be discontinued where there is a formal DNACPR ‘order’ or an Advance Decision (Living Will) that states the wish of the patient not to undergo attempted resuscitation, or where a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNACPR decision has been made.

North West Ambulance Service recognises the DNACPR V17 form at Appendix 1.

6.33. Review

Decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person’s condition or in their expressed wishes. This applies to a decision that CPR is appropriate as well as to a DNACPR decision. The frequency of review should be determined by the healthcare professional responsible for their care and will be influenced by the clinical circumstances of the patient. The DNACPR decision must be reviewed as a minimum every 12 months. There will be some patients for whom a DNACPR decision will be appropriate until their death and therefore review of this decision is not necessary; documentation must allow for this.

It is important to note that patients’ ability to participate in decision-making may change with changes in their clinical condition. It may not always be necessary to discuss CPR with the patient each time the decision is reviewed. The need to discuss the decision further with the patient should be determined by careful assessment in each individual situation. Where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it.

Where that decision was a shared decision with the patient (or their welfare attorney), based on a balance of benefits against harms and burdens of CPR, revision of that decision should include discussion with the patient (or those close to the patient if they have subsequently lost capacity).

The required frequency of review of CPR decisions may differ greatly between different types of care setting. It may also differ greatly between individual patients within any one care setting, so the frequency must be based on the needs of the individual patient and not on any ‘blanket’ policy. For example, in a palliative care environment frequent review of DNACPR decisions will not be necessary for many patients, but the healthcare staff should be competent to recognise those whose situation warrants more frequent review of the decision.

In its report on cardiorespiratory arrests in hospitals – Time to Intervene – the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommended that “CPR status must be considered and recorded for all acute
(hospital) admissions, ideally during the admission process and definitely at the initial consultant review when an explicit decision should be made in this group of patients, and clearly documented (for CPR or DNACPR)⁶. As noted earlier in this guidance, although the NCEPOD recommends that CPR should be considered for all acute admissions, it does not mean that it is necessary to discuss CPR with all patients admitted to hospital acutely. There are some patients who are dying from an advanced and incurable illness, for whom CPR will not work and for whom a discussion is likely to cause them to suffer harm.

6.34 Standards, audit and training

CPR decisions and their communication can be sensitive and complex. They should be undertaken by appropriately trained, competent and experienced members of the healthcare team. Organisations providing healthcare must ensure that their clinical staff have adequate training and up-to-date knowledge to make appropriate decisions about CPR and communicate them effectively. CPR should be performed competently and in accordance with current national and international guidelines.

7.1 TRAINING

- This is included on all BLS, ILS and ALS training sessions provided by the Resuscitation Team
- DNACPR training will be included in the bi-annual junior doctor induction training sessions
- Included at Induction to all new clinical staff
- Annual presentation of DNACPR Audit Report to Care Group Governance Committees

8.1 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trusts’ monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.
Monitoring of the policy:
9.0 REFERENCES/BIBLIOGRAPHY

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2. Do not attempt cardio-pulmonary resuscitation. Integrated Adult Policy.

3. Published by the Scottish Government May 2012. NHS Scotland www.scotland.gov.uk


8. Recognition of life extinct (ROLE) by ambulance staff. Joint Royal Colleges Ambulance Liaison Committee. 2003. www.jrcalc@asa.uk.uk
10.0 RELATED TRUST POLICY/PROCEDURES
POL/001/002 – Resuscitation Policy
This DNA CPR decision applies only to CPR treatment where the child, young person or adult is in cardiopulmonary arrest

- In this individual, CPR need not be initiated and the hospital cardiac arrest team or paramedic ambulance need not be summoned
- The individual must continue to be assessed and managed for any care intended for health and comfort - this may include unexpected and reversible crises for which emergency treatment is appropriate
- All details must be clearly documented in the notes

Name: NHS no: Address: Date of birth: Postcode: Place where this DNA CPR decision was initiated:

If an arrest is anticipated in the current circumstances and CPR is not to start, tick at least one reason:

☐ There is no realistic chance that CPR could be successful due to: ..................................................

☐ CPR could succeed, but the individual with capacity for deciding about CPR is refusing consent for CPR

☐ CPR could succeed but the individual, who now does not have capacity for deciding about CPR, has a valid and applicable ADRT or court order refusing CPR

☐ This decision was made with the person who has parental responsibility for the child or young person

☐ This decision was made following the Best Interests process of the Mental Capacity Act

YES NO Has there been a team discussion about CPR in this child, young person or adult?

YES NO Has the young person or adult been involved in discussions about the CPR decision?

YES NO Has the individual’s personal welfare lasting power of attorney (also known as a health and welfare LPA), court appointed deputy or IMCA been involved in this decision?

YES NO Has the individual agreed for the decision to be discussed with the parent, partner or relatives?

YES NO Is there an emergency health care plan (EHCP) in place for this individual?

Key people this decision was discussed with Details of discussions must be recorded (see box right)

Junior doctor (must have GMC licence plus full registration and agree DNA CPR with responsible clinician below before activating DNA CPR)

Sign: Status: GMC no: Date: Time:

Name:

Senior responsible clinician (If a junior doctor has signed, the senior responsible clinician must sign this at the next available opportunity)

Sign: Status: GMC/NMC no: Date: Time:

Name:

For those individuals transferring to their preferred place of care

If the individual has a cardiopulmonary arrest during the journey, DNA CPR and take the patient to:

The original destination Journey start Try to contact the following key person

Status: Tel:

Name:

This DNA CPR is valid for 12 months from either the date of the initial signing or the last review date

Check for any change in clinical status that may mean cancelling the DNA CPR.

Reassessing the decision regularly does not mean burdening the individual and family with repeated decisions, but it does require staff to be sensitive in picking up any change of views during discussions with the individual, partner or family.

Any senior responsible clinician who knows the patient can review the DNA CPR decision

Date review was done Name and signature of reviewer

Review if the patient or persons discussed with ask for a review or whenever the condition or situation changes

Form originally developed by the NHS North East Deciding right initiative

DNACPR Policy Page 35 of 39
Making a CPR decision

It is often appropriate to consider CPR in assessing a patient but, if there is no reason to anticipate an arrest, a clinician cannot make a DNACPR decision in advance. A patient with capacity retains the right to refuse CPR in any circumstances.

Consequences:
- The young person or adult with capacity must be given opportunities to receive information or an explanation about any aspect of their treatment. If the individual wishes, this may include information about CPR treatment and its likely success in different circumstances.
- Continue to communicate progress to the individual (and to the partner/family if the individual agrees).
- Continue to elicit the concerns of the individual, partner or family.
- Review regularly to check if circumstances have changed

In the event of an unexpected arrest: carry out CPR treatment if there is a reasonable possibility of success (if in doubt, start CPR and call for help from colleagues, arrest team or paramedics).

It is likely that the individual is going to die naturally because of an irreversible condition. Consent is not possible since CPR is not an available option, but communication about end of life issues should continue.

Consequences:
- Document the reason why there is no realistic chance that CPR could be successful, eg. “Deterioration caused by advanced cancer.”
- Continue to communicate progress to the patient (and to the partner/family if the patient agrees or if the patient lacks capacity). This explanation may include information as to why CPR treatment is not an option.
- Continue to elicit the concerns of the individual, partner, family or parents.
- Review regularly to check if circumstances have changed
- To allow a comfortable and natural death effective supportive care should be in place, with access if necessary to specialist palliative care, and with support for the partner, family or parents.
- If a second opinion is requested, this should be respected.

In the event of the expected death, AND (Allow Natural Dying) with effective supportive care in place, including specialist palliative care if needed.

- In children and young people: discuss the options with the person who has parental responsibility.
- In adults: check if there is a valid and applicable Advance Decision to Refuse Treatment (ADRT) refusing CPR, a registered and signed Personal Welfare (Health & Welfare) Lasting Power of Attorney order (with its accompanying 3rd party certificate) with the authority to decide on life-sustaining treatment, or a court appointed deputy is involved. The most recent order takes precedence. Otherwise the decision must be made following the Best Interests process as required by the Mental Capacity Act, with the decision-making process clearly documented. If nobody is available to speak for the individual or there is disagreement amongst the family, appoint an Independent Mental Capacity Advocate (IMCA).

- When there is only a small chance of success and there are questions whether the burdens outweigh the benefits of attempting CPR: the involvement of the individual in making the decision is paramount if they have the capacity to make this decision.

In case of serious doubt or disagreement further input should be sought from a local Clinical Ethics Advisory Group or, if necessary, the courts.

CPR should be attempted unless the individual has capacity and states that they do not want CPR attempted

- Decisions about CPR can be sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully.
- Decisions should be reviewed regularly and when the circumstances change.
- Advice should be sought if there is any uncertainty over a CPR decision.
APPENDIX 2 –
RESUSCITATION PLAN FOR CHILDREN

RESUSCITATION PLAN

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
</tr>
<tr>
<td>Unit Number/RNN:</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Mobile</td>
</tr>
</tbody>
</table>

DIAGNOSIS

GUIDELINE:
This guideline has been agreed by ......................’s parents and medical staff. In case of a life threatening occurrence this guideline should be used unless the medical or nursing staff present or ......................’s parents feel that they need to be altered.

SAFE  Shout for help and call parents

A.  AIRWAY
   • Airway clearing manoeuvres should be attempted
   • Oral suction may be attempted
   • NOT for intubation

B.  BREATHING
   • Use Oxygen as required
   • NOT for bag and mask ventilation

C.  CARDIAC AND CIRCULATION
   • NOT for cardiac compression
   • NOT for resuscitation drugs

D.  OTHERS
   e.g. seizures, infection, deterioration in health

Child and Family Wishes Guidance, Association for Children’s Palliative Care
www.act.co.uk
THIS PLAN MAY CHANGE AT THE PARENTS REQUEST IN THE ACUTE SITUATION OR AFTER DISCUSSION WITH THE LEAD CONSULTANT

........................................

........................................

Parents

........................................

Consultant Paediatrician

........................................

Other

DISTRIBUTION LIST (address and telephone number)

Parents

Lead Consultant

General Practitioner

Health Visitor / School Nurse

Professionals involved

Accident and Emergency

Ambulance Service

Hospice

Tertiary Specialists

Child and Family Welfare Guidance, Association for Children’s Palliative Care www.act.co.uk

END OF DOCUMENT
DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) POLICY