



**Dorset
Clinical Commissioning Group**

NHS Dorset Clinical Commissioning Group

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Adult Policy



Supporting people in Dorset to lead healthier lives

**DO NOT ATTEMPT
CARDIO PULMONARY
RESUSCITATION
(DNACPR)
ADULT POLICY**

PAN DORSET

PREFACE

In 2007 members from a range of NHS and independent organisations providing care for patients at the end of their lives in Dorset agreed a common Do Not Attempt Resuscitation Form. In August 2011 a wide stakeholder group met to review the use of the form and agreed that a pan Dorset DNACPR policy for adults should be introduced. This provides clear guidance for local NHS staff and others providing end of life care about when attempted resuscitation should and should not take place, taking into account the wishes of patients.

In 2015 a review of the policy was undertaken, led by the Quality Directorate of Dorset CCG. This has taken into account national guidance since 2009 and included contributions from Senior Health Care professionals across all providers of care within Dorset.

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DORSET CLINICAL COMMISSIONING GROUP

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1. INTRODUCTION

- 1.1 The purpose of Cardiopulmonary Resuscitation (CPR) is the prevention of sudden unexpected death (American Heart Association 1974, Resuscitation Council (UK) 2010), for instance the sudden loss of cardiac output associated with ventricular fibrillation or ventricular tachycardia. In patients for whom CPR is attempted, the reported success rate is 5 to 20% (Nichol 2008, Reisfield 2006). However, for most patients with advanced progressive disease, death occurs after a period of gradual deterioration (Wilcock and Crosby 2009) and in these circumstances the likelihood of survival after attempted CPR is extremely low (close to 0%) (Ewer et al 2001 Murphy and Finucane 1993).
- 1.2 Resuscitation Council (UK) 2010 Guidelines state that “improved knowledge, training, and do-not-attempt-resuscitation (DNAR) decision-making should improve patient care and prevent futile CPR attempts. Patients for whom CPR will not prolong life, but may merely prolong the dying process, should be identified early.”
- 1.3 “A Do Not Attempt CPR (DNACPR) or Allow a Natural Death (AAND) decision should be considered when the patient:
- does not wish to have CPR, or;
 - will not survive cardiac arrest even if CPR is attempted.” (Resuscitation Council (UK) 2014).

2. POLICY STATEMENT

- 2.1 The Dorset-wide DNACPR policy will ensure the following:
- all people are presumed to be “For CPR” unless:
 - * a valid DNACPR decision has been made and documented;
 - * an Advance Decision to Refuse Treatment (ADRT) prohibits CPR.
- 2.2 Please note, if the person has capacity a verbal request to decline CPR should be taken into account and should they subsequently lose capacity, be considered when making a best interests decision. The verbal request needs to be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make an ADRT to ensure the verbal request is adhered to.
- 2.3 There will be some patients for whom attempting CPR is inappropriate; for example, a patient who is at the end stages of a terminal illness. In these circumstances CPR would not restart the heart and breathing of the individual, and should therefore not be attempted.

- 2.4 When there is a clear clinical need for a DNACPR/ AAND decision in a dying patient for whom CPR offers no realistic prospect of success that decision should be explained to the patient, unless it is judged that this would cause significant physical and psychological harm, in which case this must be clearly documented. Those close to the patient should be informed at the earliest practicable opportunity
- 2.5 All DNACPR decisions are based on current legislation and guidance.
- 2.6 If cardiac or respiratory arrest is a clear possibility for the patient and there is a realistic chance that CPR could be successful, and the patient has the capacity to make the decision, the patient must be involved in deciding whether or not CPR will be attempted in the event of cardio respiratory arrest. Patients have a right to refuse to have these discussions.
- 2.7 If a patient lacks capacity and cardiac or respiratory arrest is a clear possibility and there is a realistic chance that CPR could be successful, discussions with those close to the patient must be used to guide a decision in the patient's best interests. If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, this must be respected. If an attorney, deputy or guardian has been appointed they should be consulted.
- 2.8 A standardised form for adult DNACPR/ AAND decisions will be used (see Appendices 1 & 2).
- 2.9 Effective communication concerning the individual's resuscitation status will occur among all members of the multidisciplinary healthcare team involved in their care and across the range of care settings. This could include carers and relatives if appropriate.
- 2.10 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 decision. The patient and those close to the patient have no right to insist on treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.
- 2.11 The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.
- 2.12 Training will be available to enable staff to meet the requirements of this policy.
- 2.13 This policy was originally reviewed by legal services to ensure it provides a robust framework underpinned by relevant national documents.

3. PURPOSE

3.1 This policy will provide a framework to ensure that DNACPR decisions:

- respect the wishes of the individual, where possible;
- reflect the best interests of the individual;
- provide benefits that are not outweighed by burden.

3.2 This policy will provide clear guidance for health and social care staff.

3.3 This policy will ensure that DNACPR/AAND decisions refer only to CPR and not to any other aspect of the individual's care or treatment options.

4. SCOPE

4.1 This policy applies to all of the multidisciplinary health, social care and tertiary care teams involved in patient care across the range of settings within Dorset.

4.2 This policy can be applied to all individuals over the age of 18.

4.3 This DNACPR policy forms part of the Advance Care Planning for patients and should work in conjunction with end of life care planning for individuals.

5. DEFINITIONS

Cardiopulmonary resuscitation (CPR)

5.1 An emergency procedure which may include chest compressions and ventilations in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation Council (UK) guidelines.

Cardiac Arrest

5.2 Is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal gasping respiration.

Mental Capacity Act -2005 (MCA)

5.3 Was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.

Mental Capacity

- 5.4 This policy relates to those over 18 years of age. It is noted that an individual over the age of 16 (between 16-18 years are treated under the Children and young person's Advance Care Planning Policy) is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary.

Individuals who lack capacity will not be able to:

- understand the information relevant to the decision; and/or
- retain that information; and/or
- use or weigh that information as part of the process of making the decision; and/or
- communicate the decision, whether by talking or sign language or by any other means.

Advance Decision to Refuse Treatment (ADRT)

- 5.5 A decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

- 5.6 Refers to not making efforts to restart breathing and/or the heart in cases of respiratory / cardiac arrest. It does not refer to any other interventions/treatment and/or care such as fluid replacement, feeding, antibiotics etc.

Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA)

- 5.7 The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to appoint a LPA for health and welfare. Under a Power of Attorney, the attorney can make decisions that are as valid as one made by the person (the donor) as expressed in the LPA.

Independent Mental Capacity Advocate (IMCA)

- 5.8 An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them. They must be consulted when a decision about either serious medical treatment or a long term move is being made.

A Court-Appointed Deputy

- 5.9 A Court-Appointed Deputy is appointed by the Court of Protection to make decisions in the best interests of those who lack capacity.

Health and Social Care Staff

- 5.10 Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.

6. LEGISLATION AND GUIDANCE

Legislation

- 6.1 Under the Mental Capacity Act (2005) health and social care staff are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.
- 6.2 The following sections of the Human Rights Act (1998) are relevant to this policy:
- the individual's right to life (article 2);
 - to be free from inhuman or degrading treatment (article 3);
 - respect for privacy and family life (article 8);
 - freedom of expression, which includes the right to hold opinions and receive information (article 10);
 - to be free from discriminatory practices in respect to those rights (article 14).
- 6.3 Clinicians should be guided by local practice when considering reporting deaths to the Coroner. However, deaths should always be reported where the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.
- 6.4 If the individual is subject to a Deprivation of Liberty Safeguards authorisation, their death is treated as a 'death in custody' and so must be reported to the coroner – even if the death is expected and natural – before a death certificate is issued.

For more information:

Contact the Dorset Coroner's office and refer to local guidance

Or Coroners, post-mortems and inquests: Directgov - Government, citizens and rights

www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

6.5 Equality Impact Assessment (EIA) (Appendix 3) is completed at the end of this policy.

Guidance

6.6 The Resuscitation Council (UK):

- Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement Guidance from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing.(Previously known as the 'Joint Statement') 3rd edition October 2014.

- Decisions Relating to Cardiopulmonary Resuscitation

www.resus.org.uk/pages/dnar.pdf

6.7 Guidance relating to ADRT from the National Council for Palliative Care:

- The Mental Capacity Act in Practice
- Good Decision Making - The Mental Capacity Act and End of Life Care

www.ncpc.org.uk/publications

6.8 The Mental Capacity Act Code of Practice 2007.

7. ROLES AND RESPONSIBILITIES

7.1 This policy and its forms/appendices are relevant to all health and social care staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed by the local authority or employed privately by an agency.

7.2 The decision to complete a DNACPR/AAND form should be made by a Consultant/ General Practitioner (or Doctor who has been delegated the responsibility by their employer) or Registered nurse who has achieved the required Accreditation. Registered Nurses must complete the recognised competency training and have full support and agreement for this enhanced role from their line manager.

7.3 The Lead for End of Life and Cancer in the Dorset Clinical Commissioning Group is responsible for:

- ensuring that this policy adheres to statutory requirements and professional guidance;
- supporting the unified policy development and the implementation in other organisations;
- ensuring that the policy is monitored;
- reviewing the policy, form and supporting documentation every two years.

7.4 Chief Executives of provider organisations are responsible for:

- recognition and adoption of this Pan Dorset Policy;
- governance compliance for the policy and procedure;
- procuring and/or providing legal support.

7.5 Directors or Managers responsible for the delivery of care must ensure that:

- staff are aware of the policy and relevant local policies how to access them;
- the policy is implemented;
- staff understand the importance of issues regarding DNACPR;
- staff are trained and updated in managing DNACPR decisions;
- the policy is audited annually ensuring that the audit results are fed back into ELCQuA or other recognised monitoring systems ;
- DNACPR/AAND forms, leaflets and associated guidance are available as required.

7.6 Consultants / General Practitioners and Registered Nurses with accreditation, who are responsible for making DNACPR decisions must:

- be competent to make the decision;
- ensure that DNACPR forms are completed fully and accurately;
- verify any decision made by a delegated professional at the earliest opportunity. Acute trusts must ensure that a DNACPR decision is verified by a professional with overall responsibility (Consultant in acute settings) at the earliest opportunity;
- ensure the decision is documented in the patient's records (See 8.6);

- make efforts to involve the individual in the decision and, if not appropriate, document why on the DNACPR/AAND form;
- where appropriate, involve relevant others in the making of the decision and record this on the DNACPR/AAND form;
- communicate the decision to other health and social care providers involved in the patient's care;
- record a review date, only where this is felt to be necessary.

7.7 When a patient is ready to be discharged from an acute hospital the DNACPR decision must be reviewed. The Consultant responsible for the patient's care must confirm whether the decision is still valid. The final section of the form must then be completed at discharge.

7.8 Health and social care staff delivering care in all settings must:

- adhere to the policy and procedure and complete forms accurately and fully;
- notify their line manager of any training needs;
- sensitively enquire to the existence of a DNACPR or an ADRT;
- check the validity of any decision;
- cascade any decisions to staff involved in the patient's care;
- notify other services of the DNACPR decision or an ADRT on the transfer of a person;
- ensure that the DNACPR/AAND form travels with the person on transfer between care providers, and those transporting the person are aware of the decision (a clear photocopy is acceptable at this point, unless this is known to be a permanent transfer when the original should be sent with the person);
- if the original form transfers with the patient a copy should be held in the transferring organisation's record;
- participate in the audit process;
- ensure that DNACPR forms, leaflets, policy and associated guidance are available as required;
- encourage the individual, where able, to inform those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

7.9 The Ambulance service staff must:

- adhere to the policy and procedure;
- notify their line manager of any training needs;
- ensure that they are aware of the existence of a DNACPR/AAND decision or an ADRT either via the individual/relatives or the health care professional requesting assistance;
- communicate information already known within their organisation to those providing care at that time via internal communication systems;
- check the validity of the documentation;
- participate in the audit process.

7.10 Commissioners and Commissioned Services must:

- ensure that services commissioned, implement and adhere to the policy and procedure as per local contracts;
- ensure that pharmacists, dentists and others in similar healthcare occupations are aware of this policy;
- ensure DNACPR/AAND education and training is available;
- ensure audit of Trusts compliance with Dorset DNACPR/AAND paperwork, record of decision making, and any complaints/ clinical incidents involving the policy.

7.11 All staff involved in the transfer of care of a patient need to ensure that:

- the patient/or those close to the patient, if they lack capacity, have been informed of the DNACPR/AAND and are aware of where the documentation is held;
- the decision is communicated to all members of the health and social care team involved in the patient's ongoing care and added to electronic patient records where available;
- in circumstances where it has been inappropriate to have a DNACPR/AAND discussion with the patient, the reasons for this are clearly documented on the DNACPR/AAND form.

8. PROCESS

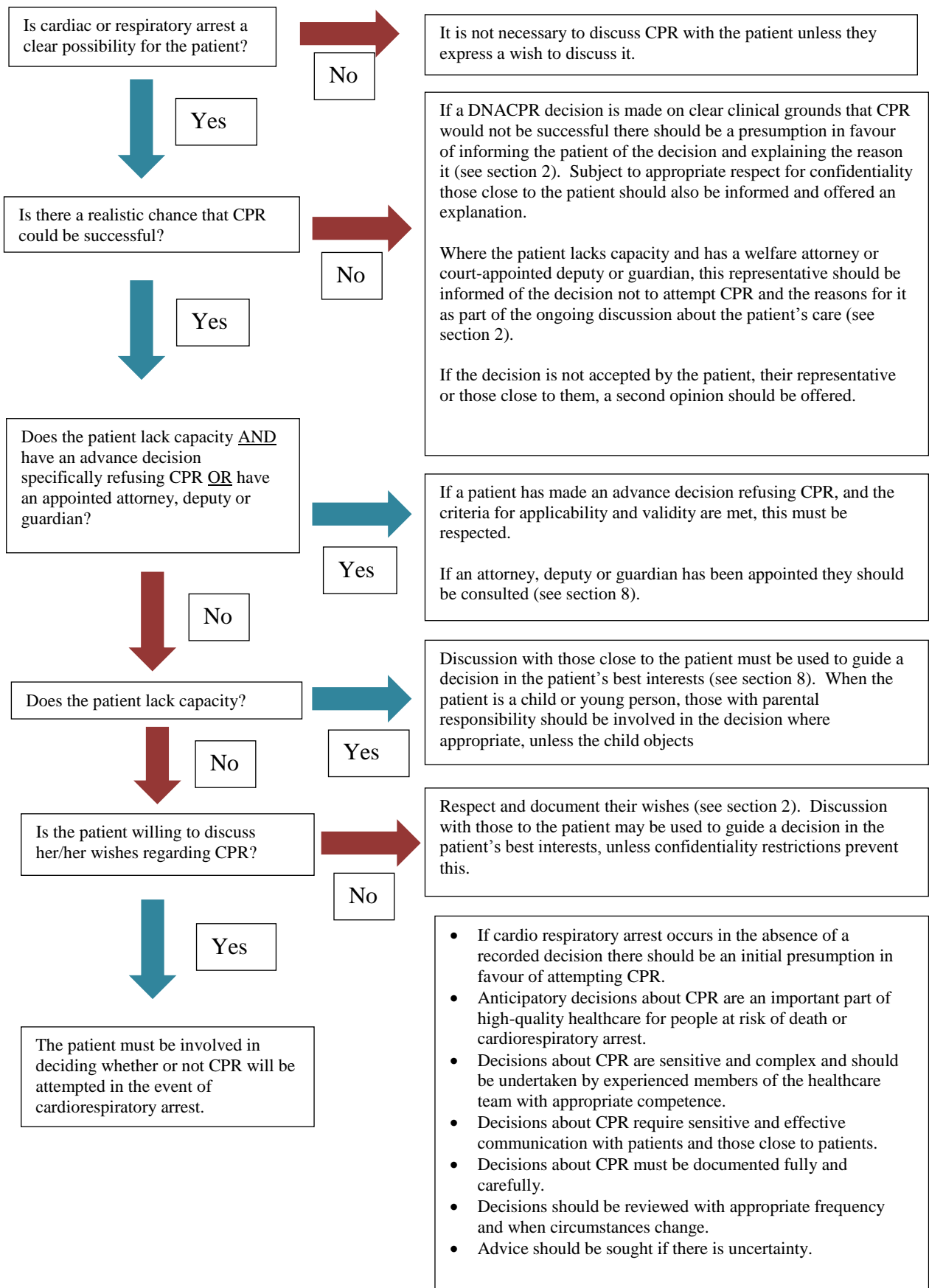
- 8.1 For the majority of people receiving care in hospital or community setting, the likelihood of cardiopulmonary arrest is small; therefore no discussion of such an event routinely occurs unless raised by the individual.
- 8.2 In the event of an unexpected cardiac arrest CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless:
- a valid DNACPR/AAND decision or an ADRT is in place and made known;
 - a suitably empowered LPA or Court Appointed Deputy is present at the point of the arrest, this individual will then make the decision regarding commencement of CPR if authorised to do so;
 - there is clear evidence of a recent verbal refusal of CPR as this will need to be carefully considered when making a best interests decision.
- 8.3 In the event of professionally qualified health care staff finding a person with no signs of life and clear clinical signs of prolonged death, and with no DNACPR decision or an ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR (Some organisations may define other health care staff within this section). Consideration of the following will help to form a decision, based on their professional judgement which can be justified and later documented:
- what is the likely expected outcome of undertaking CPR?
 - is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading if futile?
 - additionally the Joint Royal Colleges Ambulance Liaison Committee Guidelines (JRCALC) 2012 applies to Ambulance staff.
- 8.4 The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:
- where the individual's condition indicates that effective CPR is unlikely to be successful or if successful is unlikely to be sustained;
 - when CPR is likely to be followed by a length and quality of life not acceptable to the individual;
 - where CPR is not in accord with the recorded, sustained wishes of the individual who is deemed mentally competent or who has a valid applicable ADRT.
- 8.5 The decision-making framework is illustrated on page 13. When considering making a DNACPR decision for an individual it is important to consider the following:

- is Cardiac Arrest a clear possibility for this individual? If not it may not be necessary to go any further;
- if Cardiac Arrest is a clear possibility for the individual, and CPR may be successful, will it be followed by a length and quality of life that would not be of overall benefit to the patient? The patient's views and wishes in this situation are essential and must be respected. If the person lacks capacity, a LPA can make the decision, if the terms of their LPA specifies that they have the power to make such decisions. If a LPA has not been appointed a best interests decision will be made in line with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice 2007;
- if Cardiac arrest is a clear possibility for the individual and it is unlikely that CPR will be successful, the individual should be allowed to die a natural death;
- provided the clinician has demonstrated a rational process in decision making, the employing organisation will support the member of staff if this decision is challenged.

8.6 If a DNACPR decision is deemed appropriate the following needs to be considered:

- if a patient has capacity, it should be explained to him/her that an "Allow a Natural Death" decision has been made. However, if the clinician believes that such an explanation will cause physical or psychological harm (which is more than distress) the decision need not be discussed with the patient. There is no obligation on doctors to offer or give futile treatments, and clinicians should not feel pressurised either to attempt CPR inappropriately or to force harmful discussions on patients;
- if a discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, this must be clearly documented in their notes, stating the reasons why; information should not be withheld simply because it is difficult, uncomfortable or may cause the patient distress;
- if a DNACPR/AAND decision is made and there has been no discussion with the patient, for whatever reason or because they have indicated a clear desire to avoid such discussion this must be documented and the reasons recorded;
- if a DNACPR/AAND decision is made following discussion with the patient/ relevant others, this must be documented on the form and, if applicable, in their notes. Information should not be withheld simply because it is difficult or uncomfortable.
- DNACPR/AAND decisions should not be delayed because relatives are not available. If it is not possible to contact the relatives or friends, ensure that this is recorded. The record must be updated once there has been communication with them. See Decision-making framework on the next page.

The decision-making framework illustrated below will help support the process.



- 8.7 **Documenting and communicating the decision** - once the decision has been made it must be recorded on the Dorset wide approved Adult Form (see Appendix 1/Appendix 2) and recorded in the patient's notes.
- 8.8 If using an electronic format ensure one copy is printed, signed and given to the patient or carer.
- 8.9 Copies of the original form are acceptable to disseminate the decision, and may have a red border added to aid recognition by all parties.
- 8.10 Information regarding the background to the decision, the reasons for the decision, those involved in the decision and a full explanation of the process must be recorded on the form in the individual's notes/care records/care plans.
- 8.11 The form will stay with the person. It will be located in the following places:
- **hospitals, nursing and residential homes, in-patient specialist palliative care setting:** in a specified section of the person's notes, usually in the front;
 - **in the home:** If appropriate it should be left with the patient's notes within the home, indicated by the use of the 'message in a bottle' system, already well known to emergency services. If it is not appropriate the DNACPR decision must be communicated to all relevant services.
- 8.12 The location of the DNACPR form needs to be clearly stated to the Out of Hours service and a system needs to be in place to ensure effective communication of the DNACPR form's location to all relevant parties including the emergency ambulance and Out of Hours services, if these services are liable to come into contact with the person during their care (Appendix 3)
- **GP surgeries:** ensure that the DNACPR decision is recorded in the individual's electronic record and summary care record and also using the appropriate Read Code. The form should be kept with the patient's notes within their care setting as above. It would be good practice that the 'message in a bottle system' is used to highlight the exact place of the form within a patient's own home (as above);
 - **the completed form will be sent through to the Out of Hours service (OOHs) using the special message system (faxing at present).** OOHs will ensure the information is then sent to the emergency ambulance service. Where a person is an inpatient in an acute unit with 24hr medical cover this information does not need to be shared with the OOHs services until the person leaves that care i.e. transfer to another care setting on a temporary or permanent basis;
 - **ambulance transfer:** Ambulance crews must ensure that if there is a DNACPR decision made, the completed original form or a clear copy of the form is given to the crew prior to transfer. This will include recognised DNACPR forms from neighbouring counties (e.g. lilac form used in Hants/ South Central area);

- the transferring ambulance crew need to communicate any pre-existing DNACPR decision to the receiving clinical team;
- **non-ambulance transfer:** between departments, other healthcare settings and home should be informed and abide by the DNACPR decision.

8.13 **Confidentiality:** If the individual has the mental capacity to make decisions about how their clinical information is shared their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity, clinicians may disclose confidential information to people close to them where this is necessary to discuss the individual's care and is in the person's Best Interests.

8.14 Any delegated decision that is made must be verified by the Clinician responsible for the patient's care at the earliest opportunity,

8.15 It is best practice that the decision is endorsed, at the earliest opportunity, when there is a change in lead clinician. This is not a legal requirement and the decision remains valid until this is done.

9. IMPLANTABLE CARDIO-VERTER DEFIBRILLATORS (ICDs) AT END OF LIFE

Respect for patient autonomy

9.1 Patients have a right to make decisions about their own health care, and health professionals have a duty to help patients to make these decisions, by providing impartial advice and information about treatment options, including the option of stopping or refusing treatment. Good clinical practice emphasises the importance of shared decision-making between health professionals and patients and, if appropriate, their families throughout the course of the person's illness.

9.2 Changes in circumstances – including the progression of the patient's disease, any complications, or the development of new treatments – mean that the doctor and patient will need to reappraise decisions about management of the illness. A patient who consented to having an ICD implanted when he or she was generally well, but at risk of life-threatening arrhythmias, might make a different decision when dying from end-stage heart failure or another life-limiting disease, if given the opportunity to do so.

9.3 It is important to allow patients to revise or reinforce previous decisions in the light of subsequent events, so that they can determine as far as possible the course that their life should take.

9.4 Clinicians caring for patient who has an ICD should therefore, regularly review with the patient and their cardiology team how relevant this treatment is and, when appropriate, with the involvement of the cardiology team, introduce the possibility

of deactivating the defibrillator function to avoid the patient experiencing distressing symptoms.

Acting in the patient's best interests

- 9.5 When a patient is unable to make decisions on their own behalf, health professionals caring for them have a moral and legal duty to act in the patient's best interests. An assessment of best interests includes balancing the risks and benefits associated with any given treatment. In most cases an ICD will confer greater benefit than harm to a patient. However, in some situations, the possibility that recurrent ICD activation might prevent a comfortable death could be judged to outweigh any benefit of prolonging life for a brief period of time.
- 9.6 If a patient with an ICD does not have the capacity to make his or her own decisions, those responsible for their care should consider whether ICD activation is still in the patient's best interests, given the patient's particular condition and circumstances. This would be part of an overall consideration of what is optimal care for the patient, in discussion with the patient's family and taking into account the patient's previous wishes if known.
- 9.7 A consensus view based on a multidisciplinary team approach would apply well in this situation and it may be particularly helpful to seek the advice of specialists in palliative care. Any such process must comply with the Mental Capacity Act 2005.
- 9.8 The patient's cardiology team must be contacted after the decision for DNACPR/AAND has been made to ensure the correct decision is made with regard to timely deactivation of the ICD.
- 9.9 More complex internal cardiac devices e.g. Left Ventricular Assist Device (LVAD) should be discussed with the specialist centre when a patient is approaching end of life.

10. REVIEW

- 10.1 This decision will be regarded as **'Indefinite'** unless:
- a definite review date is specified;
 - there are changes in the person's condition, which would warrant review;
 - their expressed wishes change, in which case the decision should be reviewed. However, in these circumstances it may not be clinically appropriate to change the decision (See 10.3).
- 10.2 If a review date is specified then the health care staff with overall responsibility (or a delegated representative) must contact all relevant ongoing care givers to inform them of the need for a review. This contact must initially be by phone/ in person and

then followed up with a discharge letter to ensure that the details of the review are clear to all concerned. Informal reviews can take place at any time.

- 10.3 It is important to note that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, each time that a DNACPR decision is reviewed, the reviewer must consider whether the person can contribute to the decision-making process. It is not usually necessary to discuss CPR with the person each time the decision is reviewed, if they were involved in the initial decision. Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

11. SITUATIONS WHERE THERE IS A LACK OF AGREEMENT

- 11.1 A person with mental capacity may refuse CPR, despite having no clinical reason to do so; in these circumstances they should be encouraged to write an ADRT. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. An ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the ADRT but it is not essential.
- 11.2 Please note if the person has capacity prior to arrest, a verbal request to decline CPR should be taken into account and considered when making a best interests decision at time of arrest. The verbal request needs to be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make an ADRT to ensure the verbal request is adhered to. (see Mental Capacity Act).
- 11.3 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a DNACPR/AAND form in their possession. An appropriate sensitive discussion with the person should aim to secure their understanding and acceptance of the DNACPR decision and in some circumstances a second opinion may be sought to aid these discussions.
- 11.4 Individuals do not have a right to demand that doctors carry out treatment against their clinical judgement. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice may be indicated. This should very rarely be necessary.

12. CANCELLATION OF A DNACPR DECISION

- 12.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated, signed and name printed by the health care professional. It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision.

- 12.2 On cancellation of the DNACPR/AAND form or death of the person the health care professional should inform the Ambulance Service that cancellation or death has occurred so that records can be updated. In the event of a cancellation of a decision due to a death this information can be sent to the OOH's service on a monthly basis so records can be updated regularly.

13. SUSPENSION OF A DNACPR DECISION

- 13.1 In the following circumstances DNACPR decision may be temporarily suspended, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances:
- **acute:** Where the person suffers an acute, unforeseen, but immediately life threatening situation such as anaphylaxis or choking. CPR would be appropriate while the reversible cause is treated;
 - **pre-planned:** Some procedures could precipitate a cardiopulmonary arrest for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people including the patient, if appropriate, will need to take place.

14. AUDIT

- 14.1 The Clinical Commissioning Group (CCG) will measure, monitor and evaluate compliance with this policy through audit and data collection using the Key Performance Indicators (KPI).
- 14.2 All organisations will have clear governance arrangements in place which indicate individuals and committees who are responsible for the governance of this policy at a local level and that can respond to the CCG request for audit purposes.

This includes:

- data collection;
- ensuring that approved documentation is implemented;
- managing risk;
- sharing good practice;
- monitoring of incident reports and complaints regarding the DNACPR process;
- developing and ensuring that action plans are completed.

14.3 Frequency and information:

- compliance with the policy will be audited annually and the audit results fed back into recognised monitoring systems;
- local leads will decide the number of DNACPR forms to be examined.

14.4 Information will be used for future planning, identification of training needs and for policy review.

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ACKNOWLEDGEMENT

Informed by NHS South of England (South Central) Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy – 2012

Appendix 1 DNACPR form

Appendix 2 AAND form

Appendix 3 Recommendations to ensure DNACPR decisions are communicated to those involved in the patients care

Appendix 4 Equality Impact Assessment

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 18 years and over

Name: Address: Post code: Date of birth: / / NHS or hospital number: □□□ □□□ □□□□	 Date of DNAR Order / / <div style="border: 1px solid red; padding: 5px; color: red; text-align: center;">PLEASE KEEP ORIGINAL IN COLOUR</div>
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In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1	Does the patient have capacity to make and communicate decisions about CPR? If 'YES' go to box 2 Yes <input type="checkbox"/> No <input type="checkbox"/> If 'NO', are you aware of a valid advance decision refusing CPR which is relevant to the current condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'NO' has the patient appointed a Welfare Attorney to make decisions on their behalf? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'YES' they must be consulted. If NO consider appointing an IMCA All other decisions must be made in the patient's best interests and comply with current law. Go to box 2
2	Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: (If the patient has an ICD, contact the local cardiology dept (arrhythmia nurse) for guidance)
3	Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:
4	Summary of communication with patient's relatives or friends:
5	Names of members of multidisciplinary team contributing to this decision:
6	Healthcare professional completing the DNAR order Name: _____ Position: _____ Signature: _____ Date: / / Time: _____
7	Review and endorsement by most senior healthcare professional, GP or medic: This is: <input type="checkbox"/> an Indefinite decision / <input type="checkbox"/> Needs review Review date: / / Signature: _____ Name: _____ Date: / / Signature: _____ Name: _____ Date: / /
8	Only complete this section for patients in the community or on discharge from hospital GP name: _____ Surgery: _____ Tel No: _____ GP Informed: Yes <input type="checkbox"/> No <input type="checkbox"/> Care provider informed: Yes <input type="checkbox"/> No <input type="checkbox"/> Ambulance/ OoH's informed: Fax: 01202 851305 <input type="checkbox"/> tick when completed

Reverse of DNAR Form

Reverse of DNAR Form

This form should be completed legibly in black ball point ink

All sections should be completed

- the patient's full name, date of birth and address should be written clearly;
- the date of writing the order should be entered;
- this decision will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified;
- the decision should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home;
- if the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. Capacity / advance decisions

Record the assessment of capacity in the clinical notes. Ensure that any advance decision refusing CPR is valid (must be written, signed and witnessed, and must include a statement that the advance decision is to apply even if life is at risk), and is applicable in the patient's current circumstances. (see point 4 below re: IMCA).

16 and 17-year-olds: Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests

Be as specific as possible.

3. Summary of communication with patient (or welfare attorney if appointed and if patient lacks capacity)

State clearly what was discussed and agreed. The patient must be informed of the decision unless it is judged that this would cause significant physical or psychological harm, in which case this must be clearly documented. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney with authority to make decisions about life-sustaining treatment on their behalf, that person must be consulted if the patient lacks capacity.

4. Summary of communication with patient's relatives or friends

If the patient does not have capacity and if cardiorespiratory arrest is foreseen and CPR has a realistic prospect of success, their relatives or friends must be consulted to ascertain the patient's relevant wishes, feelings, beliefs and values. This information must be considered when making the best interests decision regarding CPR. If there are no relatives or friends known, an IMCA referral can be made (referrals@dorsetadvocacy.co.uk 030034370000).

If CPR has no realistic prospect of success, relatives and friends should be informed about all DNACPR decisions unless there is a good reason not to do so. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. Members of multidisciplinary team

State names and positions of those involved in making this decision. Ensure that the DNAR decision has been communicated to all relevant members of the healthcare team.

6. Healthcare professional completing this DNAR decision

This will vary according to circumstances and local arrangements. Within this Policy this should only be made by the most senior healthcare professional immediately available (i.e doctor, nurse specialist/practitioner who has undertaken recognised training).

7. Endorsement / review

The decision must be endorsed by the medical practitioner responsible for the patient's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed or whenever circumstances change. A fixed review date is not recommended.

8. Informing others

It is the responsibility of the healthcare professional completing the form and subsequently those endorsing the decision to ensure that the appropriate agencies are informed of the existence of this order.

Reverse of AAND Form

Reverse of AAND Form

This form should be completed legibly in black ball point ink

All sections should be completed

- the patient's full name, date of birth and address should be written clearly;
 - the date of writing the order should be entered;
 - this decision will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified;
 - the decision should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home;
 - if the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the order.
- 1. Capacity / advance decisions**

Record the assessment of capacity in the clinical notes. Ensure that any advance decision refusing CPR is valid (must be written, signed and witnessed, and must include a statement that the advance decision is to apply even if life is at risk), and is applicable in the patient's current circumstances. (see point 4 below re: IMCA).

16 and 17-year-olds: Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.
 - 2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests**

Be as specific as possible.
 - 3. Summary of communication with patient (or welfare attorney if appointed and if patient lacks capacity)**

State clearly what was discussed and agreed. The patient must be informed of the decision unless it is judged that this would cause significant physical or psychological harm, in which case this must be clearly documented. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney with authority to make decisions about life-sustaining treatment on their behalf, that person must be consulted if the patient lacks capacity.
 - 4. Summary of communication with patient's relatives or friends**

If the patient does not have capacity and if cardiorespiratory arrest is foreseen and CPR has a realistic prospect of success, their relatives or friends must be consulted to ascertain the patient's relevant wishes, feelings, beliefs and values. This information must be considered when making the best interests decision regarding CPR. If there are no relatives or friends known, an IMCA referral can be made (referrals@dorsetadvocacy.co.uk 030034370000).

If CPR has no realistic prospect of success, relatives and friends should be informed about all DNACPR decisions unless there is a good reason not to do so. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
 - 5. Members of multidisciplinary team**

State names and positions of those involved in making this decision. Ensure that the DNAR decision has been communicated to all relevant members of the healthcare team.
 - 6. Healthcare professional completing this DNAR decision**

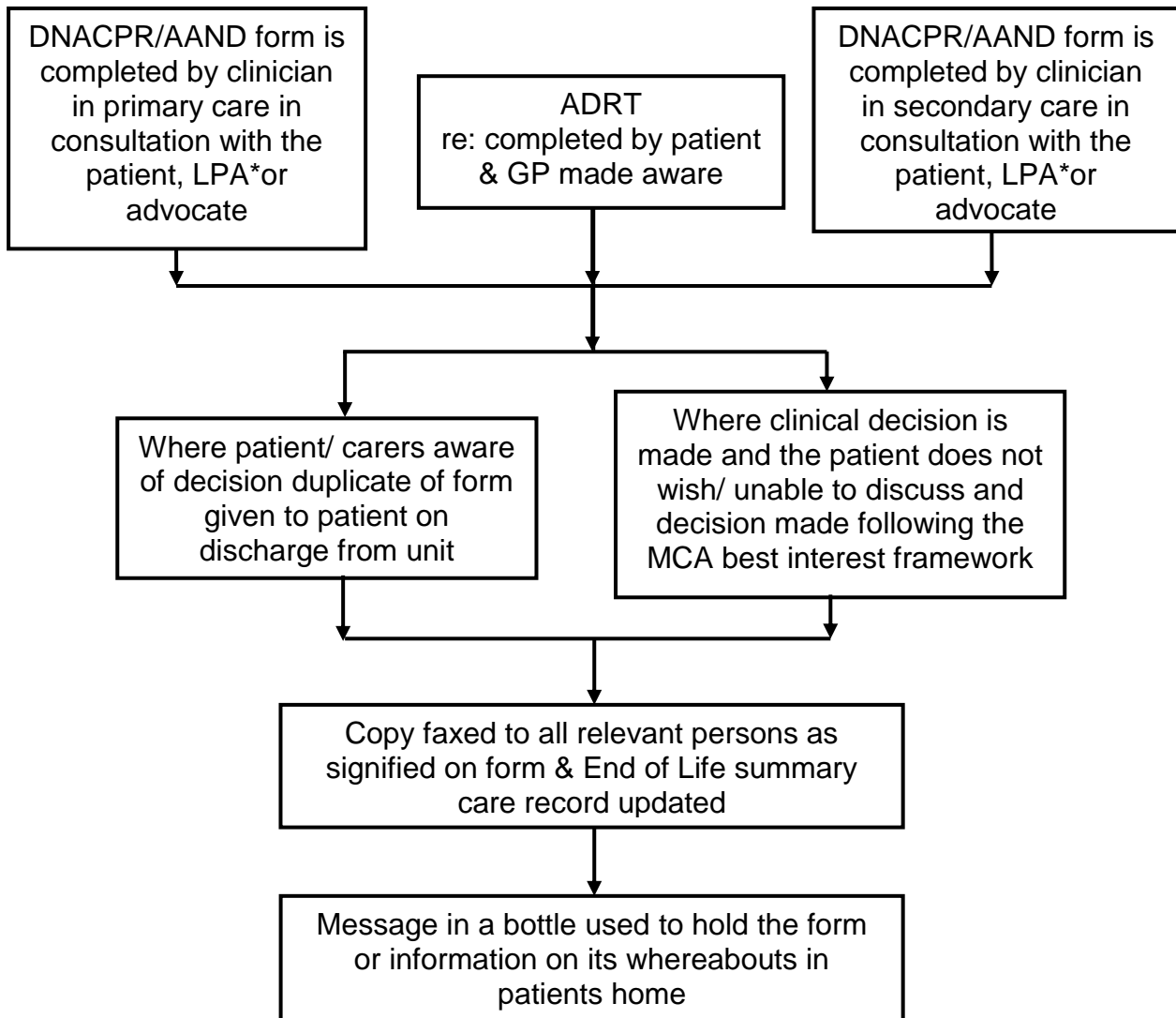
This will vary according to circumstances and local arrangements. Within this Policy this should only be made by the most senior healthcare professional immediately available (i.e doctor, nurse specialist/practitioner who has undertaken recognised training).
 - 7. Endorsement / review**

The decision must be endorsed by the medical practitioner responsible for the patient's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed or whenever circumstances change. A fixed review date is not recommended.
 - 8. Informing others**

It is the responsibility of the healthcare professional completing the form and subsequently those endorsing the decision to ensure that the appropriate agencies are informed of the existence of this order.

Recommendations to ensure DNACPR decisions are made in line with the Tracey Judgment (2014) and communicated to those involved in the patients care

***LPA must be Health and Welfare**



Equality Assessment Form

Strategy or project title:
<p>What are the intended outcomes of this work? <i>Include outline of objectives and function aim</i></p> <p>For all staff in Health and Social Care providers and residents in Dorset to be aware of the strategy and process for making and documenting resuscitation decisions at end of life.</p>
<p>Who will be affected? <i>E.g. staff, patients, service users etc.</i></p> <p>Staff, patients and public.</p>
Evidence
<p>What evidence have you considered? <i>List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.</i></p> <p>See reference section in the policy.</p>
<p>Disability <i>Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.</i></p> <p>Not relevant.</p>
<p>Gender <i>Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).</i></p> <p>No relevant</p>
<p>Race <i>Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i></p> <p>Not relevant.</p>
<p>Age <i>Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i></p> <p>Not relevant.</p>
<p>Gender reassignment (including transgender) <i>Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.</i></p> <p>Not relevant.</p>

<p>Sexual orientation Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.</p> <p>Not relevant.</p>
<p>Religion or belief Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.</p> <p>Not relevant.</p>
<p>Pregnancy and maternity Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.</p> <p>Not relevant.</p>
<p>Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.</p> <p>Not relevant.</p>
<p>Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.</p> <p>Not relevant</p>

<p>Engagement and involvement</p>		
<p>Have you engaged stakeholders in gathering evidence or testing the evidence available? If not what do you intend to do?</p> <p>All generalist and specialist providers have engaged with the review and all comments taken into account.</p>		
<p>How have you engaged stakeholders in testing the policy or programme proposals? If not what do you intend to do?</p> <p>This is a policy review which has been undertaken in the light of the previous practice under the same policy.</p>		
<p>If you have engaged groups please list below and include who was involved, how they were involved and the key outputs:</p>		
<p>Groups engaged</p>	<p>Date and type of engagement</p>	<p>Outputs from activity</p>
<p>Virtual end of life care group – general ad specialist providers, acute hospitals, community provider, hospice are, primary care etc</p>	<p>By email and direct meetings starting March 2015</p>	<p>Feedback included in the review.</p>

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

All feedback collated and taken into account in conducting the review.

Equality Act 2012– *the CCG is bound by the public sector equality duty and is required to evidence how in its decisions it is delivering the following. Please outline how your work and the service will contribute to these.*

Eliminate discrimination, harassment and victimisation

This policy is intended for use by all providers of care and does to ensure equity of provision and best practice standards for Dorset residents

Advance equality of opportunity

As above

Promote good relations between groups

The policy is dependent on consistent application of the agreed procedures by all parties,

What is the overall impact of your proposals or decision? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

Not applicable.

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

None.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

Continue to record feedback, incidents and complaints as a result of application of the policy to inform the next review.

Name of person who carried out this assessment: : Jaydee Swarbrick, Professional Practice Lead

Date assessment completed: 28.08.15

CCP lead: Dr Lionel Cartwright

Date assessment was signed: 7/9/15

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the specific actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation			
<ul style="list-style-type: none"> • Data collection and evidencing 			
<ul style="list-style-type: none"> • Analysis of evidence and assessment 			
<ul style="list-style-type: none"> • Monitoring, evaluating and reviewing 			
<ul style="list-style-type: none"> • Transparency (including publication) 			

Please return a copy to Ebi Sosseh Equalities and Human Rights Lead: Ebi.Sosseh@dorsetccg.nhs.uk once completed who will review it and ensure that it is published on the website. A signed hard copy and electronic copy should be kept within your department for audit purposes.