

Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)



NHS Creative

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Paper specification

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Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Re-order items

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Information for you,
your relatives and carers about
**Do Not Attempt
Cardiopulmonary Resuscitation
decisions**



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What happens if...?


Planning ahead for the needs of children and
young people with life-limiting or
life-threatening conditions



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What is an Advance Care Plan?

Planning ahead for the needs
of young people with life-limiting or
life-threatening conditions



LILAC FORM TO PERSON - WHITE FORM FOR AUDIT
UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)
In the event of cardiac or respiratory arrest no attempts at CPR will be made. All other appropriate treatment and care will be provided.

Name: _____
 Address: _____
 Date of birth: _____
 NHS or hospital number: □□□ □□□ □□□□

Date of DNACPR Decision: _____/_____/_____
 Form completed electronically? Yes No
South Central
 Before completing this form, please see explanation notes.

1. Reason for DNACPR decision
 A) CPR is unlikely to be successful due to _____
 This decision has been discussed with the person
 Name of relevant other: _____ Yes No
 B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person.
 Name of relevant other: _____ Yes No
 • Person involved in discussions? Yes No
 • Person lacks mental capacity and has a legally appointed Welfare Attorney: Name _____
 • Person lacks mental capacity and does not have a legally appointed Welfare Attorney: Name _____
 C) DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.
 Name of the person in discussion with (Name): _____
 Valid and applicable Advance Decision to Refuse Treatment (ADRT) seen? Yes No
 Name of the person who is mentally competent: _____
 Signature: _____ Position: _____ Date: _____/_____/_____ Time: _____

2. Healthcare professional making this DNACPR decision:
 Name: _____ Position: _____
 Signature: _____ Date: _____/_____/_____ Time: _____
 Healthcare professional making this DNACPR decision if original decision made by professional without overall responsibility for the person's care:
 Name: _____ Position: _____
 Signature: _____ Date: _____/_____/_____ Time: _____

3. Review
 Review date if appropriate: _____/_____/_____
 Name: _____ Position: _____
 Signature: _____ Date: _____/_____/_____ Time: _____
 Outcome of review: DNACPR to continue? Yes No
 Name: _____ Position: _____
 Date: _____/_____/_____ Time: _____

4. Who has been informed of this DNACPR decision?
 Person
 Acute Trust
 Out of Hours
 GP
 Nursing Home
 Other (Please state) _____
 Ambulance
 Hospice
 Relative (Name) _____
 Community Hospital _____

5. Ambulance crew instructions:
 a) In the event of Cardio Pulmonary arrest, please do not attempt CPR or defibrillation for this person.
 b) All other types of supportive care should be given.
 c) If whilst in transit the person suddenly demonstrates continue journey and try to contact destination:
 Destination Name & telephone no. _____
 Next of Kin Name & telephone no. _____
 d) If whilst in transit the person dies talk to nearest Mortuary / Emergency
 Name: _____
 Address: _____
 Date of birth: _____
 NHS or hospital number: □□□ □□□ □□□□