Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – Adult Policy

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Purpose of Agreement	This policy provides guidance to staff in relation to all aspects of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. The policy provides a clear framework that should be followed with all patients under the care of Solent NHS Trust to ensure the appropriate use of DNACPR decisions alongside promoting a holistic approach to care.
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1	August 2021	Susan Jennings	Policy Steering Group, Clinical Executive Group	Policy rewrite

SUMMARY OF POLICY

Cardiopulmonary resuscitation (CPR) is a treatment which can be commenced for anyone whom cardiac or respiratory function ceases. A person going into cardiorespiratory arrest can be inevitable and is part of the dying process. The purpose of CPR is to restore pulmonary and cardiac function for a person in a way which is sustainable. As with any treatment, CPR should only be offered if there are clear expectations that its aim can be achieved.

When it is clear in advance that attempts at CPR would be unsuccessful and/or an inappropriate treatment option for a person, it is essential that this information is shared in a clear but sensitive manner with the patient; unless there is clear evidence that a conversation regarding DNACPR could result in significant physical and/or psychological harm to the individual.

In circumstances where a patient lacks capacity, their relatives/relevant others should be contacted to discuss the decision unless this goes against a patient's prior wishes to discuss the clinical decision regarding DNACPR. Relatives should always be contacted at the soonest convenience and in a way which is sensitive, contacting the relatives should never delay the implementation of a DNACPR for a person.

It is also essential to identify individuals who have expressed their wishes regarding not wishing to be resuscitated in the event of a cardiac and/or respiratory arrest. Some individuals may have an Advanced Decision to Refuse Treatment (ADRT) which may have documented the persons wishes regarding resuscitation. If an ADRT has very specific guidance regarding CPR and has met the current legal requirements for ADRT documentation, then the persons wish must be respected regarding their wish not to be resuscitated if stated.

The DNACPR form (Appendix B) is used to document and maintain effective communication regarding the reason for the DNACPR decision:

- Section 1a: should be completed for a DNACPR decision where CPR will not be successful.
- Section 1b for patients where CPR may be successful but will be followed by a length and quality of life which would not be overall benefit to the person.
- Section 1c when a patient has an Advanced Decision to Refuse Treatment to aide clarity of the decision made regarding resuscitation.

The purpose of this policy is to prevent inappropriate, contraindicated and/or unwanted attempt at CPR which would not be beneficial to the care of a patient and could lead to significant distress to patients and families. A person dying during an inappropriate CPR attempt may result in an undignified death for the person. An inappropriate CPR attempt may also involve South Central Ambulance Service (SCAS) and occasionally the police, which can add greater distress to the family and others involved. This policy supports the wider aim of ensuring a person's wishes and goals in relation to their care are respected at the end of life, irrespective of whether they are at home, in hospital, a hospice or a care home.

It must be remembered that this policy and DNACPR decisions are non-discriminatory documents and a DNACPR cannot be made against a person's Human Rights as detailed within the Human Rights Act 1998, or be implemented for reasons of discrimination (Equality Act 2010) To support this an Equality Impact Statement (Appendix A) has been completed within the formulation of this policy.

There is often confusion and uncertainty regarding CPR and the process of making advanced decisions in which a DNACPR will be implemented. By maintaining a consistent approach in decision making, documentation and communication misunderstanding can be avoided, which can lead to harmful and distressing incidents for patients, families, and staff. A single, integrated approach to this complex part of good end of life care is an essential aspect for all patients within the Wessex region and those under the care of Solent NHS Trust.

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DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) – ADULT POLICY

1. INTRODUCTION & PURPOSE

1.1. This policy is an adapted version of the NHS South of England (Central) Unified DNACPR Adult Policy for use within Solent NHS Trust.

1.2. The chance of survival following Cardiopulmonary Resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Although CPR can be attempted on any person prior to death, there comes a time for some people where it is not in their best interest to undertake this clinical intervention. It may then be appropriate to consider making a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision to enable the person to die with dignity.

1.3. This policy should be read in conjunction with Solent NHS Trust CLS19 Resuscitation and Deteriorating Patient Policy.

1.4. All patients are presumed to be "For CPR" unless:

- A valid DNACPR decision has been made and documented on the standardised Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) form for adult DNACPR decisions (see Appendix B)
- An Advance Decision to Refuse Treatment (ADRT) prohibits CPR

1.5. Please note if there is clear evidence of a recent verbal refusal of CPR whilst the person had capacity, then this should be carefully considered when making a best interest decision. Good practice means that the verbal refusal should 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 refusal is adhered to.

1.6. There will be some patients for whom attempting CPR is inappropriate; for example, a patient who is at the end stage of a terminal illness. In these circumstances' CPR would not restart the heart and breathing of the individual and should therefore not be attempted. To minimise any confusion, it would be advisable that these patients have a DNACPR decision made and that documentation is in place, although this may not always be the case.

1.7. All DNACPR decisions are based on current legislation and guidance, and a standardised form for adult DNACPR decisions will be used to document the decision.

1.8. This policy will provide clear guidance for clinical staff and a framework to ensure that DNACPR decisions:

- refer only to CPR and not to any other aspect of the individual's care or treatment options.
- respect the wishes of the individual, where possible.
- reflect the best interests of the individual.
- provide benefits that are not outweighed by burden.

2. SCOPE AND DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community, and our staff.

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

2.4 This policy is applicable to all individuals aged 18 and over and will guide Solent NHS Trust staff on the decision-making process and regulations surrounding Do Not Attempt Cardiopulmonary Resuscitation decisions.

2.5 Definitions

- **Adult:** A person aged 18 years and over

- **Advance Decision to Refuse Treatment (ADRT):** a decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.

- **Cardiac Arrest (CA):** the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal gasping respiration. In simple terms, cardiac arrest is the point of death.

- **Cardiopulmonary Resuscitation (CPR):** Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

- **Court-Appointed Deputy:** is appointed by the Court of Protection (Specialist Court for issues relating to people who lack capacity to make specific decisions) to make decisions in the best interests of those who lack capacity.
- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR):** 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 / care such as fluid replacement, feeding, antibiotics etc.

- **Independent Mental Capacity Advocate (IMCA):** 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.

- **Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA):** The Mental Capacity Act (2005) allows people over the age of 18 years of age, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and well-being on their behalf once capacity is lost.

- **Mental Capacity:** An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals that lack capacity will not be able to:
    - Understand information relevant to the decision
    - Retain that information.
    - Use or weight that information as part of the process of making the decision.
    - Communicate the decision, whether by talking or sign language and/or by other means.

- **Mental Capacity Act (2005) (MCA):** 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. Under the Mental Capacity Act (2005), clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made. Useful information on applying the MCA into clinical practice can be found in (Appendix xx).

- **NHS England South (Central):** South Central Strategic Health Authority (SHA) and the South West and South East SHA's merged in 2012 to form NHS England South. This unified DNACPR policy was developed by South Central SHA so only applies in NHS England South central region.

- **Registered Healthcare Professional:** A healthcare worker who has registration with a professional body (GDC, GMC, HCPC, NMC).

- **Recommended Summary Plan for Emergency Care and Treatment (ReSPECT):** a personalised recommendation for a person's clinical care and/or treatments in a future emergency in which they are unable to make or express choice, this can include decisions relating to CPR.

3. PROCESS & REQUIREMENTS

3.1. For most people receiving care in hospital or community setting, the likelihood of cardiopulmonary arrest (cessation of breathing and heartbeat) is small; therefore, no discussion of such an event routinely occurs unless raised by the individual or clinician. There is no ethical or legal requirement to initiate discussion about CPR with patients, or with those close to patients who lack capacity, if the risk of cardiorespiratory arrest is considered low.

3.2. In the event of an unexpected cardiac arrest, CPR will take place in accordance with Solent NHS Trusts Deterioration and Resuscitation Policy. There may be some situations in which CPR is commenced on this basis, but during the resuscitation attempt further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR decision, a valid and applicable advance decision refusing CPR or additional clinical information

indicating that CPR will not be successful. In such circumstances, continued attempted cardiopulmonary resuscitation would be inappropriate.

3.3. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing consider it appropriate for a DNACPR decision to be considered in the following circumstances:

- A person who is in the advanced stage of dying from an irreversible condition where CPR is contraindicated as being of benefit to their care.
- A person who has an advanced illness and/or deterioration of health that means a CPR attempt would most likely be unsuccessful.
- A person for whom CPR might be successful but it would result in them having a quality of life that was deemed not acceptable for the individual.
- Where a CPR attempt is not in accordance with records or a patient's sustained wishes who has capacity to make an informed decision regarding resuscitation and/or has a valid ADRT.

3.4. **Legislation**

3.4.1 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.

3.4.2 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).

3.4.3 Clinicians have a professional duty to report some deaths to the Coroner and should be guided by local practice as to the circumstances in which to do so. However, deaths must always be reported when the deceased has died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody, state detention or sectioned under the Mental Health Act 2005.

For more information see: guide to coroner services and coroner investigations a short guide: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

3.5. **DNACPR Decisions for Patients who Have Capacity**

- If CPR may be successful in re-starting a 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 a patient with capacity there should be an open dialogue and shared decision-making between the patient and professionals unless the patient declines any such discussions.

- A person with mental capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the patient's medical and nursing notes (including system one) after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an ADRT.

- In most other cases, the decision not to attempt CPR is a clinical decision. If the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not re-start the heart and breathing for a sustained period CPR should not be offered or attempted.

- The persons individual circumstances and the most up-to-date evidence and professional guidance must be considered carefully before any CPR decision is made. The ultimate responsibility for that decision rests with the most senior clinician (Consultant/GP/Registered Nurse and/or Allied Health Professional with appropriate training and maintained competency) responsible for the patients care, However, there should be:
    - Discussion of the decision whenever possible with the other members of the healthcare team to ensure their agreement or consensus.
    - A presumption in favour of, explaining the needs for and reasons for the DNACPR decision to the patient.

- Where people are known to have an advanced chronic illness, discussion, and explanation about the realities of attempting CPR should be considered and, where appropriate, offered in advance of the last few weeks or days of life.

- If a DNACPR decision is made on clear clinical grounds that CPR would not be successful, the law states there should be a presumption in favour of informing the patient of the decision and explaining the reason for it. Those close to the patient should also be informed and offered and explanation unless a patient's wish for confidentiality prevents this. There needs to be convincing reasons not to involve the patient.

- Some people make it clear that they do not wish to talk about dying or to discuss their end-of-life care, including decision relating to CPR. When such wishes are expressed, they should be respected and clearly documented.

- 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 distress. However, failure to make

timely DNACPR decision when CPR will not be successful will result in people receiving inappropriate CPR that they would not have possibly 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 and/or family at that time, but also ensure that there is active, repeated 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 possible opportunity.

- **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

3.6. **DNACPR Decisions for Patients who Lack Capacity**

- For information regarding making a capacity assessment please refer to Solent NHS Trust the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 Policy.

- For a patient who lacks capacity the requirements for an assessment and decision based on their best interests must be followed as per Mental Capacity Act 2005. It must be clearly documented in the medical notes and/or system one that a mental capacity act assessment has taken place and included the following.
    1. What is the decision that need to be made?
    2. What is the impact of or disturbance in the functioning of the mind or brain (permanent or temporary) that may affect the person's ability to make the above decision?
    3. The person is unable to understand, retain or weigh up the information to take part in the decision-making process.
    4. They are unable to communicate, whether by talking or sign language or any other means.

  Or use Hampshire Mental Capacity Act Toolkit and/or document nothing has changed from the persons previous MCA assessment.

- If a 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, deputy, or guardian does not accept the decision, a second opinion should be offered, whenever possible, although this is not a legal requirement.

- When a person lacks understanding of the information being given and a decision is made that CPR will not be attempted because it will not be successful, those close to that person must be informed of this decision and of the reasons for it, unless this is contrary to confidentiality

restrictions expressed by the patient when they had capacity. Sensitive and careful explanation is needed to help relatives 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 if the patient's next of kin/carer's are not contactable immediately to have the decision explained to them i.e. out of hours. A timely decision in the patient's best interest to provide them with high-quality care, and that decision and the reasons for making it at that point must be documented fully.

  In this situation clinicians should:

  - Record fully their reasons for not explaining a DNACPR decisions to those close to the patients at that time, documenting clearly why to do so would not be practicable or appropriate.
  - Ensure that a plan for on-going active review of the decision is recorded and implemented.
  - Ensure that a plan for informing those close to the patient of the decision at the earliest practicable and appropriate opportunity is recorded and implemented.
  - Be conscious that simply because it may be inconvenient or undesirable to inform those close to the patient of a decision at a particular time does not meet the threshold for it being practicable and appropriate.

- **Confidentiality:** Where individuals lack capacity, and their views on involving family and friends are not known health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individual's care and is not contrary to their interests.

3.7. **There is an Advanced Decision to Refuse Treatment (ADRT) and the patient lacks capacity**

- CPR must not be attempted in contrary to a valid and applicable ADRT (in England and Wales) made when the person had capacity. An ADRT is a legally binding document which must be adhered to, it is good practice to have a DNACPR form with the ADRT, but it is not essential.

- In England and Wales advanced 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:
  - 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 advanced decision has not been withdrawn
  - The person has not, since the advanced 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 advanced decision.

If an ADRT does not meet these criteria but appears to set out clear indications of the person's wishes, it will not be legally binding but should be taken into consideration in determining the person's best interest.

3.8. In the event of registered healthcare staff finding a patient 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 (Refer to Solent NHS Trusts Deterioration and Resuscitation Policy for further guidance). 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 inhumane and degrading?
- Is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interest's decision on behalf of the patient.
- Provided the registered healthcare staff has demonstrated a rationale for their decision-making, Solent NHS trust will support the member of staff if this decision is challenged. Please refer to CLS19 Deterioration and Resuscitation Policy

3.9. When considering making a DNACPR decision the decision-making framework (Appendix C) must be used to support this process and considerations of the following:

- Is cardiac arrest a clear possibility for the patient? If not, it may not be necessary to go any further.
- If cardiac arrest is a clear possibility for the patient 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 patients view and wishes in this situation are essential and must be respected. If the person lacks capacity a Lasting Power of Attorney (LPA) will make the decision. If an LPA has not be appointed a best interest decision will be made including contacting an Independent Mental Capacity Advocate (IMCA) to support this process for the patient.
- If the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss DNACPR decisions with the individual.

3.10. If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:

- The DNACPR decision is made following discussion with the patient/others, this must be documented in their notes including system one.

- The DNACPR decision has been made and there has been no discussion with the patient because they have indicated a clear desire to avoid this, then a discussion with relatives and/or carers should only take place with the patient's permission.
- If a discussion with a patient who has mental capacity regarding CPR is deemed inappropriate by medical staff, this must be clearly documented in their notes including system one.
- The DNACPR information leaflet (Appendix E) should be made available where appropriate to individuals and their relatives and carers. It is the responsibility of Solent NHS trust to ensure that different formats and languages can be made available for patients and/or their relatives when required.

3.11. **Documentation and Communication**

Documentation

3.11.1 Once the decision has been made, it must be recorded on the DNACPR form (Appendix A) and written in the person's notes. The **LILAC** form must always stay with the person.

3.11.2 The person's full name, NHS or hospital number, date of birth, date of writing decision and institution name should be completed and written clearly. The address may change due to person's deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address.

3.11.3 Scanning and/or photocopies of DNACPR decisions can be used for record keeping and auditing process **ONLY**, it cannot be used as a process to confirm a patients DNACPR status. If any copies of a patients DNACPR form are made the copy should be crossed through with two diagonal lines in black ball-point ink and the word 'COPY' written clearly between them to avoid any potential confusion that this is the original document.

3.11.4 In an inpatient environment e.g. hospitals, nursing homes, in-patient Specialist Palliative Care setting the triplicate form stays together in the front of the person's notes until death or discharge. On discharge (from the care setting instigating the form) the lilac copy of the form stays with the person; one white copy remains in the medical notes and one white copy is retained for audit purposes. For deceased people – lilac and one white copy stay in medical notes and one white copy is retained for audit purposes.

3.11.5 For people in their homes, the lilac form is placed in their home, a white copy remains in their notes at the GP's surgery (ensure that the DNACPR decision is recorded in the individual's electronic problem list using the appropriate Read Code) and the third white copy is retained for audit purposes. The tear-off slip on the lilac form should be completed and placed in the "message in a bottle" in the person's refrigerator. The location of the DNACPR form needs to be clearly stated on the tear off slip (e.g. my form is in the nursing notes in the top drawer of the sideboard in the dining room). If a "message in a bottle" is not available, a system must be put in place to ensure effective communication of the DNACPR form's location to all relevant parties including the ambulance service.

Link to Lions message in a Bottle:

https://www.lions105sc.org.uk/projects/health/messageinabottle.html

Please note:

- Where the form has been initiated by another institute it will only be the lilac copy that will be in the front of the care notes.
- If using an electronic DNACPR form ensure one copy is printed on lilac paper, signed, and given to the person. A second copy needs to be stored for audit purposes. If the DNACPR form is printed out on white paper it is not considered a legal document.
- Information regarding the background to the decision, the reason for the decision, those involved in the decision and a full explanation of the process, must be recorded in the person's notes additionally these can be recorded in care records, care plans etc.

Communication

3.11.6 It is health care staff's responsibility to ensure the implementation of a DNACPR form is appropriately communicated. It is best practice where the person is at home to inform the ambulance service using their warning flag procedure and informing the GP Out of Hours Service.

3.11.7 Communicating DNACPR decisions can be particularly challenging for healthcare professionals. However, failure to explain clearly to patients or those close to them why decisions about CPR are needed, 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.

3.11.8 The DNACPR information leaflet (Appendix E) should be made available, where appropriate, to individuals and their relatives or carers. DNACPR Patient Information Leaflet v2

3.11.9 The presence of a DNACPR decision must be included in verbal handovers between healthcare professionals and should be handwritten onto handover sheets to ensure up to date information is handed over. A patient's DNACPR status must not be written on patient boards as having it recorded in numerous places is a patient safety risk as there are multiple places to update should the patient's status change.

3.12. **Discharge/Transfer Process**

- Prior to discharge, the person, or relevant other if the person lacks capacity, MUST be informed of the DNACPR decision. If the person has capacity and it is considered that informing them of the decision would not be likely to cause distress, then this should be sensitively done. The same approach should be taken towards discussions with family members.

- In such discussions if likely to cause undue distress, then it may not be possible to place a DNACPR form in the person's home until further discussions have taken place.

- When transferring the person between settings all staff involved in the transfer of care of the person need to ensure that:
  - the receiving healthcare and/or social care setting is informed of the DNACPR decision.
  - Where appropriate, the person (or those close to the person if they lack capacity) has been informed of the DNACPR decision.
  - The decision is communicated to all member of the health and social care teams involved in the person's ongoing care.
  - The decision has been documented on the end of life care register
  - The ambulance service has been informed via the warning flag procedure (via patients GP or by contacting scas.AACP@nhs.net (SCAS), iownt.Ambulance-999-111-audit-QA@nhs.net (I.O.W Ambulance Service) Please include the patients full name, NHS number, date of birth and address).

- **Ambulance Transfer:** If discussion has taken place regarding deterioration during transfer the 'Other Important Information' section must be completed by any health care staff, stating; the preferred destination (this cannot be a public place), then name and telephone number of next of kin. If there are no details and the patient is being transferred, should they deteriorate they will be taken to the nearest Emergency Department.

- **Non-Ambulance Transfer:** Other organisations transferring patients between departments, other healthcare setting and home should be informed of, and abide by, the DNACPR decision.

- Current discharge letters must include the information regarding this decision. If the DNACPR decision has a review date it is mandatory that the discharge doctor speaks to the GP to inform them of the need for a review. This should be followed up with a discharge letter.

- **Cross Boundaries:** If a patient is discharged for a health care setting that does not use the DNACPR form (e.g. ReSPECT (Appendix D) or other DNACPR forms). Providing their form is agreed following clear governance and legal process, it will be recognised by health and social care staff, until a time that the information is transferred onto the unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) form. Therefore, a patient who lives on the borders between two healthcare services providers may have two forms depending on where they go in the region. Whenever a patient comes back into the uDNACPR region, the original form is replaced in the patient's notes or a new form written if the original is not available.

3.13. **Review of a DNACPR Decision**

A DNACPR decision will be regarding as being '**indefinite'** unless:

- A definite review date is specified
- There are improvements in the person's condition
- There expressed wishes changed where a 1b and 1c decision is concerned

If a review date is specified, then the healthcare 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.

- 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, the medical team should involve the patient and/or their representative in these discussions and inform them of the change and the reason for it.

3.14. **Situations Where There is Lack of Agreement**

- Please note if the person had capacity prior to a cardiac arrest, a previous clear verbal wish to decline CPR should be carefully considered when making a best interest decision. The verbal refusal should be documented by the person 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 refusal is adhered to (see https://www.southampton.ac.uk/healthsciences/business_partnership/services/eolc.page for Mental Capacity Act in DNACPR decision making).

- A person may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, a person can refuse to hold a DNACPR 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.

- A person does not have the right to demand that doctors carry out treatment against their clinical judgement. Where a clinical decision is seriously challenged and agreement cannot be reached, legal advice may be indicated. This should very rarely be necessary.

3.15. **Cancellation of a DNACPR Decision**

- 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 healthcare professional. The cancelled form is to be retained in the person's notes. **It is the responsibility of the health care professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision.**

- Electronic versions of the DNACPR decisions must be cancelled with two diagonal lines and the work '**CANCELLED**' typed between them, dated, sighed and name printed by the healthcare professional.

- On cancellation or death of the person at home, if the 'ambulance service warning flag' has been ticked on section 4 of the form, the health and social care staff caring for the person, **MUST** inform the ambulance service that cancellation or death has occurred.

3.16. **Suspension of a DNACPR Decision**

- Uncommonly, some patients for who a DNACPR decision has been established may develop cardiac arrest from a readily reversable cause. In such situation's CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances within an ADRT or Advanced Care Plan Documentation (ReSPECT or Equivalent).

- DNACPR decisions are based on pre-emptive clinical decisions based upon a patient's pre-existing co-morbidities. When a patient suffers an acute, unforeseen, but immediately life-threatening situation, such as anaphylaxis or choking, a healthcare professional may make a clinical decision to commence CPR whilst the reversible cause is treated. To avoid any misunderstanding in these circumstances when undertaking DNACPR discussions, clinicians must discuss with the patient and/or relevant carers, the reasons when a DNACPR decision may be suspended.

- Some pre-planned procedures could precipitate cardiac arrest, for example induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical procedures etc. Under these circumstances, the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether the DNACPR decision should be suspended. Discussions with key people, including the patients if appropriate, will need to take place.

4. ROLES & RESPONSIBILITIES

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

4.2. The decision to complete a DNACPR form should be made by a Consultant/ General Practitioner (or Doctor who has been delegated the responsibility by their employer) / Registered Nurses and Allied Health Professionals who have achieved the required competency. Registered Nurses and Allied Health Professionals must complete the recognised competency training and work within a clinical team where discussions regarding DNACPR with patients is a regular occurrence i.e. Palliative care team, End of Life Care Team. Staff must maintain competency to undertake completion of DNACPR documentation and retain any evidence of training and competency documentation.

4.3. Solent NHS Trust staff should encourage the individual or their representative, where able, to inform those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

4.4. **The Chief Executive Officer (CEO):**
The CEO has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.5. **Chief Medical Officer (CMO) and the Chief Nurse:**
The Chief Medical Officer and the Chief Nurse have a duty to ensure that this policy is appropriately implemented and periodically updated. Additionally, they should ensure appropriate standards of medical care through the revalidation process and medical leadership. They also should work with other Director colleagues to ensure appropriate structure and processes are in place to provide safe and effective patient care that provides a positive experience for patients.

4.6. **The Clinical Director and Head of Quality and Professions:**
The Clinical Directors and Head of Quality and Professions Governance are accountable for ensuring that the policy is implemented within respective services.

4.7. **Service Managers are responsible for:**

- Answering queries regarding this policy in relation to their clinical area.
- Taking any unresolved queries to the link champion or the Resuscitation service who will take it to the appropriate forum for discussion and resolution.
- Releasing and ensuring staff attend the appropriate level of resuscitation training on the required basis.
- Ensuring that an incident form is completed on Ulysses for any expected and/or unexpected deaths that occurs in their area and any other relevant documentation relating to the incident.
- Ensure that post incident support is available to staff following an expected and/or unexpected death.
- Ensure that bank or agency staff are in date with the relevant level of resuscitation training, before providing clinical cover.

4.8. **Matrons / Ward Managers and Team Leaders who provide care to patients must ensure that:**

- Staff are aware of this policy and the processes and procedures within it.
- The policy is effectively implemented (including ensuring staff have access to DNACPR forms, leaflets and the DNACPR policy as required).
- Clinical handovers include patient status reports, are relevant and include the patient's resuscitation status both internally within/or across teams and externally if transferring patients to another hospital or care setting and are documented on the appropriate platforms.
- Staff record keeping is maintained in line with the standards within this policy and Solent NHS Trust clinical record keeping standards.
- Processes are in place to ensure regular checks that practitioners have participated in appropriate training in managing DNACPR decisions.
- Staff engage with audits of the standards within the guidance as appropriate and that audit findings are acted upon and learning is shared.

- Staff adhere to the DNACPR policy and understand the importance of issues regarding DNACPR.
- Supervision and support are made available to staff as required.

4.9. **Consultants/General Practitioners making DNACPR decisions must:**

- Be competent to make decisions relating to DNACPR.
- Verify any decisions made by a delegated professional at the earliest opportunity.
- Ensure the decision is documented (See 3.11).
- Involve the individual, following best practice guidelines when making a decision, (See 3.11.7) and, if appropriate, involve relevant others in the discussion.
- Communicate the decision to other health and social care providers.
- Review the decision if necessary.

4.10. **Registered Nurse or Allied Health Professional making DNACPR decisions:**

- Be competent to make decisions relating to DNACPR.
- Ensure the decision is documented (See 3.11).
- Involve the individual, following best practice guidelines when making a decision, (See 3.11.7) and, if appropriate, involve relevant others in the discussion.
- Communicate the decision to other health and social care providers.
- Review the decision if necessary.

4.11. **Registered and non- registered Solent NHS staff delivering care must:**

- Adhere to the DNACPR policy and procedures.
- Notify their line manager of any training needs.
- Sensitively enquire as to the existence of a DNACPR or an ADRT.
- Are responsible for ensuring they are aware of patients within their care's DNACPR status and that the form is accessible for confirmation when required.
- Check the validity of any decision.
- Notify other services of the DNACPR decision or an ADRT on the transfer of a person.
- Participate in the audit process.

5. TRAINING

5.1. Training forms part of Solent NHS Trusts statutory and mandatory training requirements as set by the trusts training needs analysis for resuscitation documented within the trusts deterioration and resuscitation policy.

5.2. All Solent NHS staff must complete their annual resuscitation training as identified through the trust training need analysis (Non-Clinical Resuscitation, Basic Life Support and AED Training, Adult Deterioration and Resuscitation Training (DART), Dental Immediate Life Support (DILS).

5.3. As per learning outcomes set for resuscitation training within Solent NHS Trust the trust DNACPR policy will be discussed within trust resuscitation training provision (Basic Life Support and AED Training, Adult Deterioration and Resuscitation Training (DART), Dental Immediate Life Support (DILS).

5.4. For any healthcare staff within the trust who are responsible for the implementation of a DNACPR decision. They must attend and complete the appropriate training and competencies to support them in undertaking this clinical documentation process with patients.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 An Equality & Human Rights and Mental Capacity Act Impact Assessment has been completed for this policy and no significant Equality and Diversity or Mental Capacity Act issues haven been identified. Please refer to (Appendix A) for the full impact assessment.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 Compliance of the DNACPR policy will be monitored through both internal and external auditing of the trusts DNACPR process and monitoring compliance with the DNACPR policy.

7.2 Implementation of the policy will be reviewed depending on the area that will be scrutinised. Post incident occurrences as they occur, standards will be reviewed annual and additionally on an adhoc basis.

- Audits will be conducted by the resuscitation team, ward leads, and the Quality and Governance team as required.
- Compliance with the policy will be audited annually, as a minimum, using the agreed Trust DNACPR audit tool.
- The Trust DNACPR audit tool will be reviewed and amended as requited to ensure effective monitoring of DNACPR decisions.
- Actions will be monitored through the Deterioration and Resuscitation meeting group, resuscitation team and Quality and Governance team when required.

7.3 Non-compliance will be reported through the Deterioration and Resuscitation meeting group and an action plan implemented by this group.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management however, will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

- British Medical Association., The Resuscitation Council UK and The Royal College of Nursing (2016). *Decisions Relating to Cardiopulmonary Resuscitation* (3rd edn.). Available at: https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf
- Coroners and Justice Act (2009). London: Crown Copyright [Accessed 12th October 2009] Available at: https://www.legislation.gov.uk/ukpga/2009/25/contents
- Equality Act (2010). London Crown Copyright [Accessed 12th October 2020]. https://www.legislation.gov.uk/ukpga/2010/15/contents
- General Medical Council (2010). *Treatment and Care Towards the End of Life.* [Accessed 6th August 2020]. GMC Guidance

- Human Rights Act (1998). London: Crown Copyright [Accessed 3rd June 2009]. Available at: https://www.legislation.gov.uk/ukpga/1998/42/contents
- Mental Capacity Act (2005). London: Crown Copyright [Accessed 3rd June 2006] Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents
- NHS End of Life Care Programme & the National Council for Palliative Care (2008)
- NHS England (2017). *Advance decisions to refuse treatment A guide for health and social care professionals.* [Accessed 6th August 2020]. Available at: ADRT Guidance
- Resuscitation Council UK (2020). *ReSPECT for Healthcare professionals.* [Accessed 4th November 2020]. Available at: https://www.resus.org.uk/respect/respect-healthcare-professionals
- CLS02 The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy [Accessed 15th July 2020].
- CLS19 Deterioration and Resuscitating Patient Policy [Accessed 15th July 2020].

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity, and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Learning and Development/Resuscitation Team	
Title of Change:	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy.	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	To ensure the trust DNACPR policy follows current guidelines and legislation in relation to DNACPR decisions.	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	

Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	Within the development of this document close working has occurred with the trust Clinical education lead and the Mental Capacity Act Lead has been contacted to ensure the policy meets the requirements of the Mental Capacity Act 2005. The document has also been sent to Health Quality Professions Leads across the trust for comments in relation to the document.
Have you taken into consideration any regulations, professional standards?	Yes	British Medical Association., The Resuscitation Council UK and The Royal College of Nursing (2016). *Decisions Relating to Cardiopulmonary Resuscitation* (3rd edn.). Available at: https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf Equality Act (2010). London Crown Copyright [Accessed 12th October 2020]. https://www.legislation.gov.uk/ukpga/2010/15/contents General Medical Council (2010). *Treatment and Care Towards the End of Life.* [Accessed 6th August 2020]. GMC Guidance Human Rights Act (1998). London: Crown Copyright [Accessed 3rd June 2009]. Available at: https://www.legislation.gov.uk/ukpga/1998/42/contents Mental Capacity Act (2005). London: Crown Copyright [Accessed 3rd June 2006] Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents NHS England (2017). *Advance decisions to refuse treatment A guide for health and social care professionals.* [Accessed 6th August 2020]. Available at: ADRT Guidance

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?	Not Applicable		
Who will be responsible for monitoring and regular review of the document / policy?	Not Applicable		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

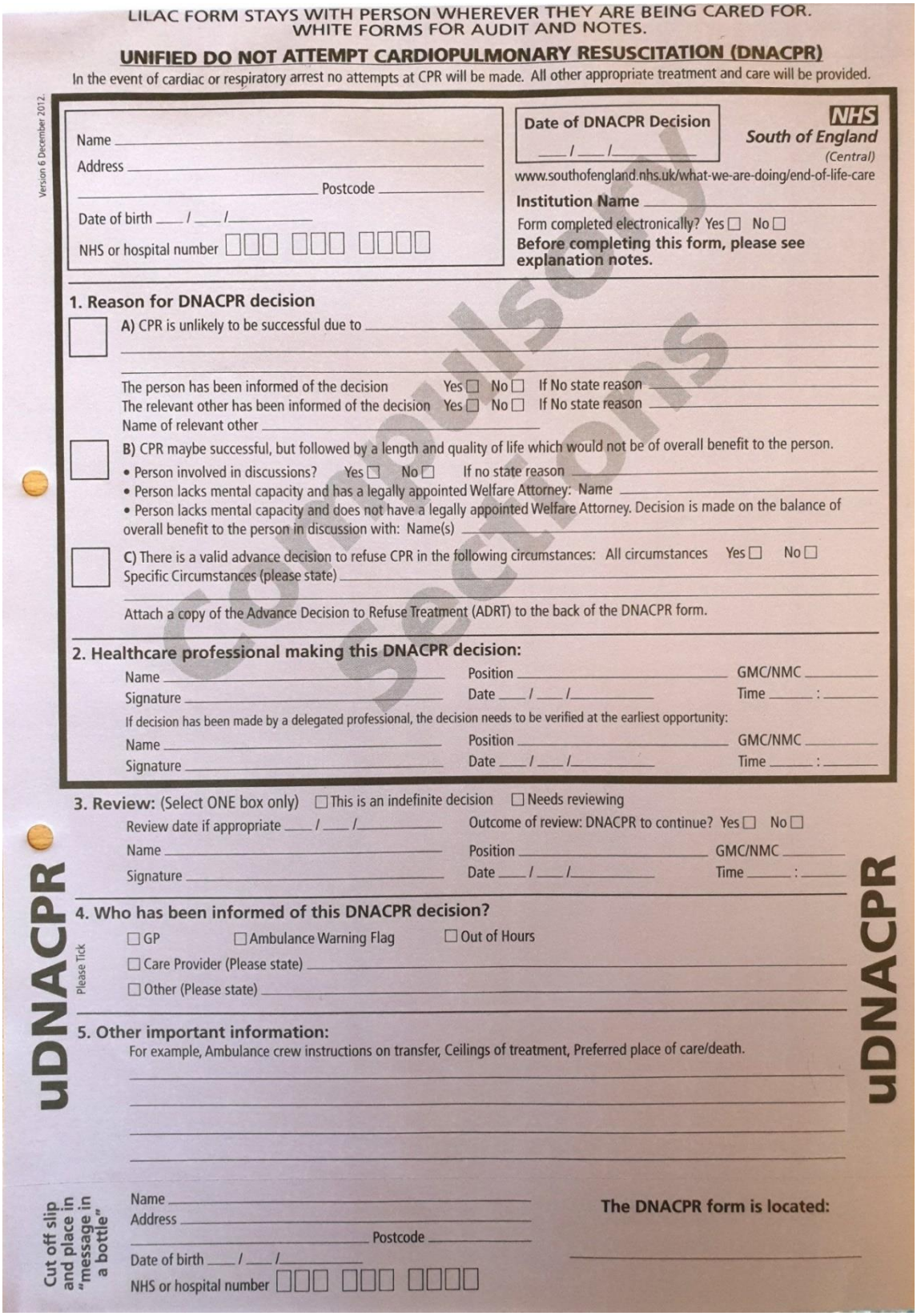
Equality Assessor:		*Date:*	

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long-term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (e.g., 18-30-year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	"The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs, including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

Appendix B: Unified DNACPR Form

This will be in triplicate format of printed on LILAC paper



LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR.
WHITE FORMS FOR AUDIT AND NOTES.

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.

Version 6 December 2012

Name _____
Address _____
_____ Postcode _____
Date of birth ___ / ___ / _____
NHS or hospital number ☐☐☐ ☐☐☐ ☐☐☐☐

Date of DNACPR Decision
___ / ___ / _____

NHS South of England (Central)
www.southofengland.nhs.uk/what-we-are-doing/end-of-life-care

Institution Name _____
Form completed electronically? Yes ☐ No ☐
Before completing this form, please see explanation notes.

1. Reason for DNACPR decision

☐ **A)** CPR is unlikely to be successful due to _____

The person has been informed of the decision Yes ☐ No ☐ If No state reason _____
The relevant other has been informed of the decision Yes ☐ No ☐ If No state reason _____
Name of relevant other _____

☐ **B)** CPR maybe successful, but followed by a length and quality of life which would not be of overall benefit to the person.

- Person involved in discussions? Yes ☐ No ☐ If no state reason _____
- 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. Decision is made on the balance of overall benefit to the person in discussion with: Name(s) _____

☐ **C)** There is a valid advance decision to refuse CPR in the following circumstances: All circumstances Yes ☐ No ☐
Specific Circumstances (please state) _____

Attach a copy of the Advance Decision to Refuse Treatment (ADRT) to the back of the DNACPR form.

2. Healthcare professional making this DNACPR decision:

Name _____ Position _____ GMC/NMC _____
Signature _____ Date ___ / ___ / _____ Time ___ : ___

If decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:

Name _____ Position _____ GMC/NMC _____
Signature _____ Date ___ / ___ / _____ Time ___ : ___

3. Review: (Select ONE box only) ☐ This is an indefinite decision ☐ Needs reviewing

Review date if appropriate ___ / ___ / _____ Outcome of review: DNACPR to continue? Yes ☐ No ☐
Name _____ Position _____ GMC/NMC _____
Signature _____ Date ___ / ___ / _____ Time ___ : ___

4. Who has been informed of this DNACPR decision?

Please Tick
☐ GP ☐ Ambulance Warning Flag ☐ Out of Hours
☐ Care Provider (Please state) _____
☐ Other (Please state) _____

5. Other important information:

For example, Ambulance crew instructions on transfer, Ceilings of treatment, Preferred place of care/death.

_____
_____
_____
_____

uDNACPR

uDNACPR

Cut off slip and place in "message in a bottle"

Name _____
Address _____
_____ Postcode _____
Date of birth ___ / ___ / _____
NHS or hospital number ☐☐☐ ☐☐☐ ☐☐☐☐

The DNACPR form is located:

_____

Compulsory Sections

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Consider using this form (as part of Advance Care Planning (ACP)), if you would not be surprised if the patient were to die in the next year. For more info on ACP please access the toolkit at *http://www.southofengland.nhs.uk/wp-content/uploads/2012/04/ACP-toolkit-v6.pdf*

This is **not** an Advance Decision to Refuse Treatment (ADRT). www.adrt.nhs.uk

Explanation Notes **This form should be completed legibly in black ball point ink**

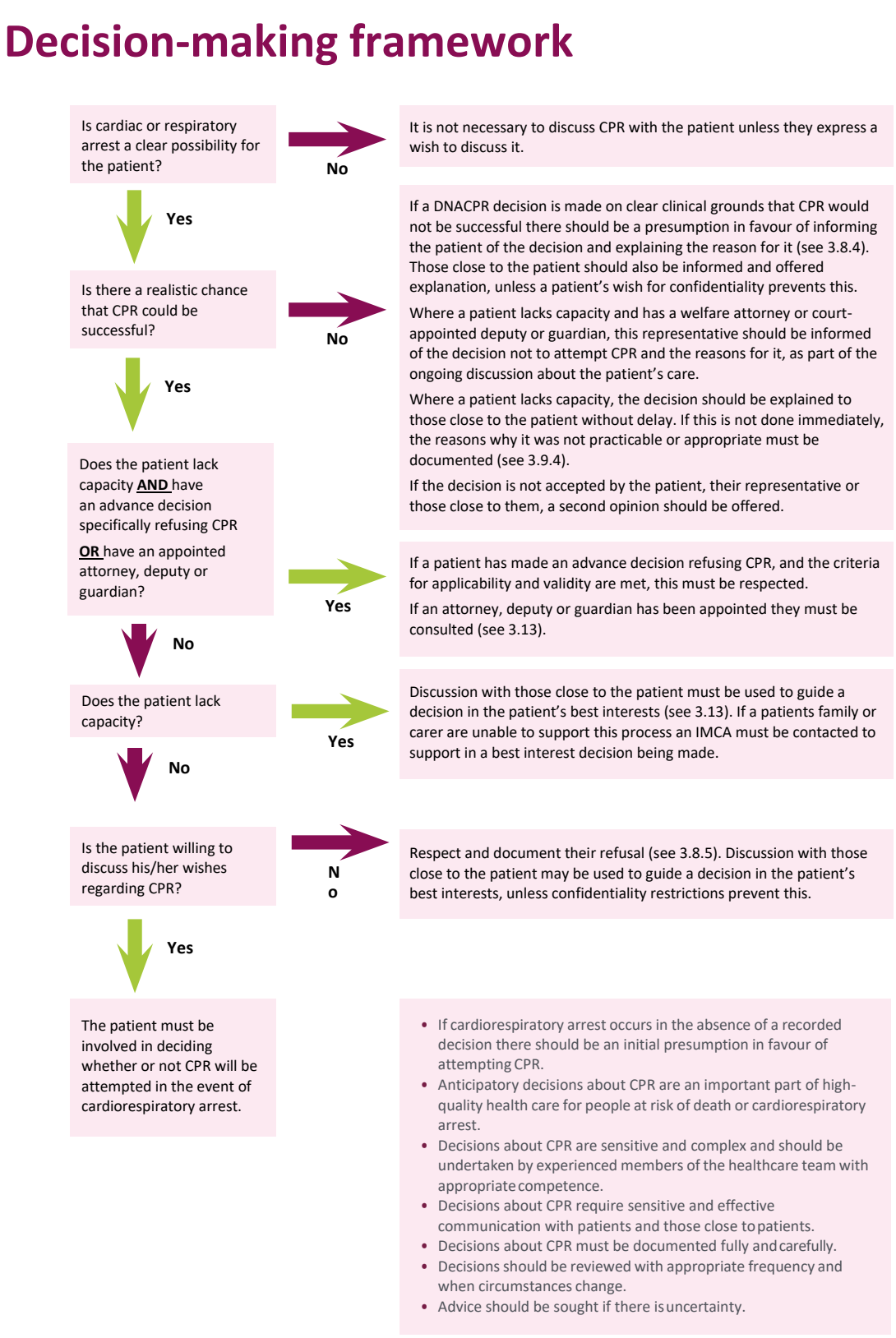
- The person's full name, NHS or Hospital number, date of birth, date of writing the decision and institution name should be completed and written clearly. Address may change due to person's deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address.
- 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 staff. It is the responsibility of the healthcare staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section **4**.on form).
- Electronic form must be printed and signed on lilac paper and copies kept for audit purposes and notes.
- Triplicate forms, keep together until person is discharged/ dies or decision is cancelled. Lilac with the person, 1st white copy for audit and 2nd white copy retain in the notes.

Compulsory sections of the form: Top section, Section 1 and Section 2.

1.	Reason for DNACPR decision	
1.A	CPR is unlikely to be successful	**Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person's best interest's.** Be as specific as possible. In this situation discussion with person / relevant other is not compulsory, although it is considered best practice to inform the person of the decision, if the person is discharged home they need to know about the decision. Record the details of discussion or the reason for not discussing in the person's notes.
1.B	CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the person	**Summary of communication with person…** State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate. If the person does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the person would decide if able to do so. If there is no one appropriate to consult and the person has been assessed as lacking capacity then an instruction to an Independent Mental Capacity Advocate (IMCA) must be considered. If the person has made a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the person if this power is included in the original Lasting Power of Attorney. You need to check this by reading the LPA. If the person has capacity ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives / relevant others with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
1.C	DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.	Check for the validity and applicability of the Advance Decision to Refuse Treatment (ADRT). Is the ADRT – 1. Specific to CPR? 2. In writing, signed and witnessed? 3. Contains the statement **'even if life is at risk'** 4. Has the person been consistent with their ADRT? If the answer to all the above is 'Yes' the ADRT is valid and applicable. If the ADRT contains specific circumstances when CPR would not be appropriate write these on the form. Attach a copy of the ADRT to the person's DNACPR form.
2.	Person making this DNACPR decision/ Verification	State names and positions. In general this should be the most senior healthcare professional immediately available. If the decision is made by a delegated professional it must be verified by the most senior healthcare professional responsible for the person's care at the earliest opportunity. If the person making the decision is the most senior person, verification is not required.
3.	Review	A fixed review date is not recommended. This decision will be regarded as "INDEFINITE" unless: i) a definite review date is specified ii) there are changes in the person's condition iii) their expressed wishes change Reviewer needs to complete all details on the form and document the outcome in the notes.
4.	Who has been informed of this DNACPR decision?	Please ensure that all health and social care staff who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the person. It is the responsibility of health and social care staff to ensure those who have been informed of the decision are informed if the patient dies, or the form is cancelled.
5.	Other Important Information	This information needs to be very clear and precise. For example, if transferring include name, address and telephone number of destination and next of kin. Ceilings of treatment include where ACP is kept. Preferred place of care should be noted.
	Tear off slip	Complete details and place in "message in a bottle" if available with location clearly stated. For example, 'In the nursing notes in the top drawer of the sideboard in the dining room.'

- For further information regarding EoLC, ordering new DNACPR forms, for the policy or for the electronic form access: *http://www.southofengland.nhs.uk/what-we-do/end-of-life-care/central-area-documents*

Appendix C: DNACPR Decision-Making Framework



Adapted from: British Medical Association., The Resuscitation Council (UK) and Royal College of Nursing (2016). *Decisions relating to cardiopulmonary resuscitation* (3rd ed.). Pg. 6.

Appendix D: ReSPECT

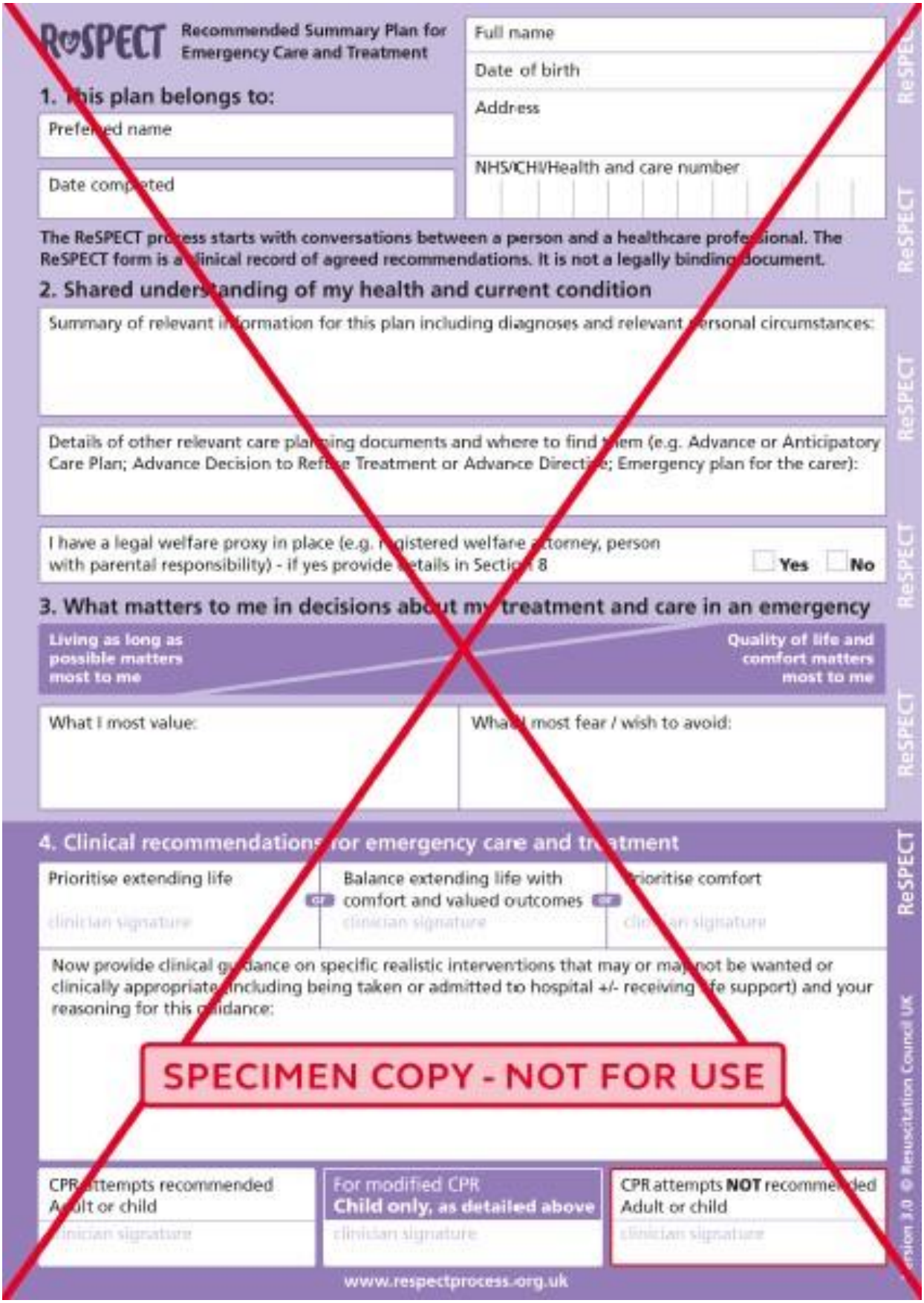
ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether CPR should be attempted if the person's heart and breathing stop.

The plan is created through conversations between a person and one or more of the health professionals who are involved with their care. The plan should stay with the person and be available immediately to health and care professionals faced with making immediate decisions in an emergency in which the person themselves has lost capacity to participate in making those decisions.

ReSPECT may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, a hospice or a hospital. Professionals such as ambulance crews, out-of-hours doctors, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to agreed clinical recommendations on a ReSPECT form.

ReSPECT conversations follow the ReSPECT process by:

1. Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future,
2. Identifying the person's preferences for and goals of care in the event of a future emergency,
3. Using that to record an agreed focus of care (either more towards life-sustaining treatments or more towards prioritising comfort over efforts to sustain life),
4. Making and recording shared decisions about specific types of care and realistic treatment that they would want considered, or that they would not want, and explaining sensitively advance decisions about treatments that clearly would not work in their situation,
5. Making and recording a shared decision about whether CPR is recommended.


ReSPECT
Recommended Summary Plan for Emergency Care and Treatment
Full name
Date of birth
Address
NHS/CHI/Health and care number
1. This plan belongs to:
Preferred name
Date completed
The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.
2. Shared understanding of my health and current condition
Summary of relevant information for this plan including diagnoses and relevant personal circumstances:
Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):
I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8
Yes
No
3. What matters to me in decisions about my treatment and care in an emergency
Living as long as possible matters most to me
Quality of life and comfort matters most to me
What I most value:
What I most fear / wish to avoid:
4. Clinical recommendations for emergency care and treatment
Prioritise extending life
clinician signature
OR
Balance extending life with comfort and valued outcomes
clinician signature
OR
Prioritise comfort
clinician signature
Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:
SPECIMEN COPY - NOT FOR USE
CPR attempts recommended
Adult or child
clinician signature
For modified CPR
Child only, as detailed above
clinician signature
CPR attempts NOT recommended
Adult or child
clinician signature
www.respectprocess.org.uk
ReSPECT
Version 3.0 © Resuscitation Council UK

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Document the full capacity assessment in the clinical record.

☐ Yes
☐ No

→ If no, in what way does this person lack capacity?

If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

☐ **D** If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

SPECIMEN COPY - NOT FOR USE

If this page is on a separate sheet from the first page: Name: DoB: ID number:

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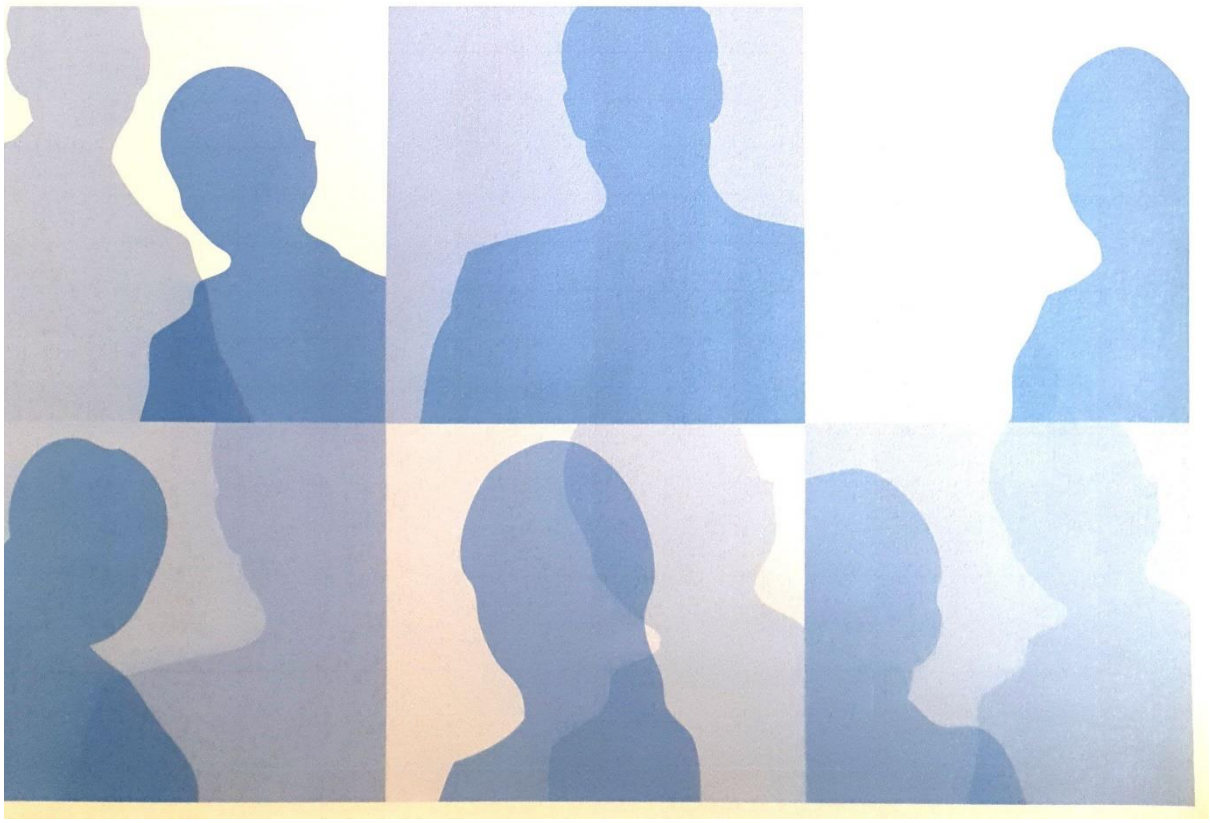
Appendix E: DNACPR Patient Information Leaflet

NHS
South of England
(Central)

Information for you, your relatives and carers about

Do Not Attempt Cardiopulmonary Resuscitation decisions



NHS
South of England
(Central)

Information for you, your relatives and carers about

Do Not Attempt Cardiopulmonary Resuscitation decisions

This leaflet explains:
What cardiopulmonary resuscitation (CPR) is
How you will know whether it is relevant to you
How decisions about it are made

This is a general leaflet for everyone over 18 (if you are under 18 there is a separate leaflet) but it may also be useful to your relatives, friends, carers and others who are important to you. This leaflet may not answer all your questions about CPR, but it should help you to think about the issue and the choices available. If you have any other questions, please talk to one of the health professionals (doctors, nurses and others) caring for you.

A DNACPR decision is about cardiopulmonary resuscitation only and you will receive all the other treatment that you need.

What is CPR?

Cardiopulmonary arrest means that a person's heart and breathing stop. When this happens it is sometimes possible to restart their heart and breathing with an emergency treatment called CPR.

CPR might include:

- **repeatedly pushing down very firmly on the chest**
- **using electric shocks to try to restart the heart**
- **'mouth-to-mouth' breathing; and**
- **inflating the lungs through a mask over the nose and mouth or tube inserted into the windpipe.**

Is CPR tried on everybody whose heart and breathing stop?

In an emergency, yes, if it is felt there is a chance it will work. For example, if a person has a serious injury or suffers a heart attack and the heart and breathing stop suddenly. The priority is to try to save the person's life.

However, if people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them. This is particularly true when people have other things wrong with them.

Where a person has expressed his / her wishes not to have CPR this must be in writing. The information in this leaflet has been written to help you to decide whether or not you want to make this decision. It is important to remember that your relatives, friends or carers cannot make the decision for you.

Do people get back to normal after CPR?

Each person is different. A few people will make a full recovery; some recover but have health problems. Unfortunately, most attempts at CPR do not restart the heart and breathing despite the best efforts of all concerned. It depends on why their heart and breathing stopped and the person's general health. It also depends on how quickly their heart and breathing can be restarted.

People who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some people never get back to the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some have brain damage or go into a coma. People with many medical problems are less likely to make a full recovery. The techniques used to start the heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs.

Am I likely to have a cardiopulmonary arrest?

This depends on your medical condition. The health professionals caring for you are the best people to discuss the likelihood of you having a cardiopulmonary arrest. People with the same symptoms do not necessarily have the same disease and people respond to illnesses differently. It is normal for health professionals and patients to plan what will happen in case of a cardiopulmonary arrest.

Somebody from the health care team caring for you, will talk to you about:

- **your illness;**
- **what you can expect to happen; and**
- **what can be done to help you.**

What is the chance of CPR reviving me if I have a cardiopulmonary arrest?

The chance of CPR reviving you will depend on:

- **why your heart and breathing have stopped**
- **any illnesses or medical problems you have (or have had in the past)**
- **the overall condition of your health.**

When CPR is attempted in hospital it is successful in 10 – 15% of cases, of these a smaller proportion will survive long enough to be discharged from hospital. In non-acute areas such as community hospitals and public places current survival is less than 5%. All of the above figures are very dependant on the patients underlying medical conditions, and illnesses such as cancer and heart disease will reduce the chance of survival further.

Does it matter how old I am or that I have a disability?

No. What is important is, your current state of health; your current wishes; and the likelihood of the healthcare team being able to achieve what you want. Your age alone does not affect the decision, nor does the fact that you have a disability.

Will I be asked whether I want CPR?

If it is appropriate you and the healthcare professional in charge of your care will decide whether CPR should be attempted if your heart and breathing stop. The healthcare team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy. Sometimes, however, restarting a person's heart and breathing leaves them with a severe disability or prolongs suffering. Prolonging life in these circumstances is not always beneficial. Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in these discussions.

Legally, your family and friends are not allowed to decide or consent on your behalf, so you should inform your family and friends of your wishes. For more information on The Mental Capacity Act please refer to: ***www.dca.gov.uk/legal-policy/mental-capacity/publications.htm*** If you have appointed a person with Personal Welfare Attorney (PWA) then they may be able to consent on your behalf in certain situations if approached.

If it is decided that CPR won't be attempted, what then?

The healthcare team will continue to give you the best possible care. The healthcare professional in charge of your care will make sure that you, the healthcare team, and the friends and family that you want involved in the decision know and understand the decision. There will be a note in your health records that you are 'not for cardiopulmonary resuscitation'. This is called a 'do not attempt cardiopulmonary resuscitation' decision or DNACPR decision.

What if I don't want to decide?

You don't have to talk about CPR if you don't want to, or you can put discussion off if you feel you are being asked to decide too much too quickly. Your family, close friends, carers or those who you feel know you best might be able to help you make a decision you are comfortable with. Otherwise, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you have said.

What if a decision hasn't been made and I have a cardiopulmonary arrest?

The doctor in charge of your care will make a decision about what is right for you. Your family and friends are not allowed to decide for you, but it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be consulted you should let you care team know.

I know that I don't want anyone to try to resuscitate me. How can I make sure they don't?

If you don't want CPR, you can refuse it and the healthcare team must follow your wishes. You can make an Advanced Decision to Refuse Treatment (ADRT) (formerly known as a living will) to put your wishes in writing. This must be signed and witnessed. If the advance decision refuses life-sustaining treatment, it must:

- **be in writing (it can be written by someone else or recorded in healthcare notes)**
- **be signed and witnessed, and**
- **state clearly that the decision applies even if 'life is at risk.'**

If you have an ADRT, you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked.

What if I want CPR to be attempted, but my doctor says it won't work?

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there was any real possibility of it being successful. If there is doubt whether CPR might work for you, the healthcare team will arrange a second medical opinion if you would like one. If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion where appropriate about whether these chances are worth taking is very important. The healthcare team will listen to your opinions and to the people close to you if you want them involved in the discussion.

What if I change my mind?

You can change your mind at any time, and talk to any of the healthcare team caring for you.

An Advance Decision is a statement made by a mentally competent person aged over 18 years which defines in advance their refusal of specific medical treatment should he/she become mentally or physically incapable of making his/her wishes known. An Advance Decision can be either a written document or a verbal statement. However, if you wish the Advance Decision to refer to life-sustaining treatment then this must be in writing.

For more information on Advance Decisions visit:
www.adrtnhs.co.uk/ www.publicguardian.gov.uk

If you feel you have not had the chance to have a proper discussion with your care team, or you are not happy with the discussions you have had you can follow the formal complaints procedure. Please do not hesitate to keep asking questions until you understand all that you wish to know.

Who else can I talk to about this?

If you need to talk about this with someone outside of your family, friends or carers, to help you decide what you want, you may find it helpful to contact any of the following:

- **Counsellors**
- **Independent Advocacy Services**
- **Patient Advice and Liaison Service (PALS)**
- **Patient Support services**
- **Spiritual carers, such as a chaplain.**

End of Life Care contact details: