Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR)

Version: 4

Summary: This policy provides guidance to staff regarding all aspects of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). It also provides a framework to ensure that DNACPR decisions respect the wishes and best interests of the individual.

Keywords (minimum of 5): (To assist policy search engine) Do Not Attempt Cardio Pulmonary Resuscitation, Mental Capacity, Decision making.

Target Audience: This policy applies to all of the multidisciplinary healthcare team involved in patient care.

Next Review Date: January 2020

Approved & Ratified by: Resuscitation Committee

Date of meeting: 5th October 2017

Date issued: October 2017

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Version 4
July 2018
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Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy

This policy is based on a unified policy agreed between the SCSHA, Trusts, Primary Care and Ambulance Services.

1. Introduction

1.1 The chance of survival following Cardio Pulmonary 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 when it is not in their best interests to do so. It may then be appropriate to consider making a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision to enable the person to die with dignity.

1.2 This policy should be read in conjunction with the Trust Medical Emergencies and Resuscitation Policy.

1.3 The Trust DNACPR policy will ensure the following:

All people are presumed to be “For CPR” unless:
- a valid DNACPR decision has been made and documented or
- a valid and applicable Advance Decision to Refuse Treatment (ADRT) prohibits CPR

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 interests 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 a valid and applicable ADRT to ensure the verbal refusal is adhered to.

1.4 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.

1.5 All DNACPR decisions are based on current legislation and guidance, in particular the Mental Capacity Act 2005 and the Mental Capacity Act 2005 Code of Practice.

1.6 When CPR might restart the heart and breathing of the individual, advanced discussion will take place with that individual if this is possible (or with other appropriate individuals for people without capacity); although people have a right to refuse to have these discussions.

1.7 A standardised documentation form for adult DNACPR decisions will be used (see appendix one).

1.8 Effective communication concerning the individual's resuscitation status will occur between 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.
1.9 DNACPR decision making process is measured, monitored and evaluated to ensure a robust governance framework.

1.10 Training will be available to enable staff to meet the requirements of this policy (see appendix 5)

2 Scope

2.1 This policy applies to all of the multidisciplinary healthcare team involved in patient care across the range of settings within the Trust

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

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.

3 Definitions

3.1 **Cardio Pulmonary Resuscitation (CPR)** 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.

3.2 **Cardiac Arrest (CA)** is 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.

3.3 **The Mental Capacity Act (2005)** (MCA), 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. (See https://www.southampton.ac.uk/healthsciences/business_partnership/services/eolc.page for Mental Capacity Act in DNACPR decision making)

3.4 **Mental Capacity**: An individual aged 16 (between 16-18 years are treated under the Children and young person’s Advance Care Planning Policy) or over is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals who lack capacity will have an impairment or disturbance in the functioning of the mind or brain that makes them unable to make a particular decision at a particular time and they will not be able to demonstrate one of the following:

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

3.5 **Advance Decision to Refuse Treatment (ADRT)**. A decision by an individual who has capacity, to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding.

3.6 **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.

3.7 **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 Health and Welfare Lasting Power of Attorney (LPA) by appointing a Personal Welfare Attorney who can make decisions regarding health and well-being on their behalf once capacity is lost and the LPA has been registered with the Office of the Public Guardian. An Attorney who is only appointed in respect of financial affairs and property has no authority to make decisions in relation to DNACPR

Paragraph 7.27 of the Mental Capacity Act 2005: Code of Practice states that if a decision relates to life-sustaining treatment (section 11(7)(c)) An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this. It also states that an attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment, if the advance decision has been made subsequent to the LPA. Both of these matters should be considered in the context of DNACPR decisions

3.8 **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. They must be consulted when a decision about either serious medical treatment or a long term move is being made.

3.9 **A Court-appointed deputy** is appointed by the Court of Protection, to make decisions in the best interests of those who lack capacity. Deputies are appointed in respect of decision making regarding an individual's property/financial affairs, or personal welfare (including healthcare) but may not refuse consent to the carrying out or continuation of life-sustaining treatment (s20 MCA 2005). However, a Deputy should be consulted in any decision making process.

3.10 **A Registered Healthcare Professional** is a qualified healthcare worker who is registered with a professional body (e.g. NMC, GDC, GMC, HCPC)

3.11 **South Central Ambulance Service NHS Trust – SCAS**

3.12 **Health and Social Care Staff** Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.

3.13 **South of England (Central) (SoE(C)) Strategic Health Authority (SHA)** South Central SHA has merged with South West and South East SHA to form NHS South of England. This policy covers the Central region only.

3.14 **ReSPECT.** ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices, this can include DNACPR decisions.

4 **Duties / 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 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 nurse who has achieved the required competency. Registered nurses must complete the recognised competency training (designed by SofE(C) SHA) and be indemnified by their organisation.

https://www.southampton.ac.uk/healthsciences/business_partnership/services/eolc.page

4.3 Health and social care 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 Resuscitation and Medical Emergency Group is responsible for:
- ensuring that this policy adheres to statutory requirements and professional guidance
- ensuring that the use and application of the policy is monitored
- reviewing the policy every 3 years.

4.5 The Chief Executive is responsible for:
- governance compliance for the policy and procedure
- procuring and / or providing legal support.

4.6 Directors or Managers responsible for the delivery of care must ensure that:
- staff are aware of the policy and how to access it
- the policy is implemented
- staff understand the importance of issues regarding DNACPR
- relevant staff are trained and updated in managing DNACPR decisions
- the policy is audited internally within the Trust within their areas of responsibility
- DNACPR forms, leaflets and policy are available as required.

4.7.1 Consultants/ General Practitioners making DNACPR decisions must:
- be competent to make the decision
- 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 at the earliest opportunity
- ensure the decision is documented (See 5.7)
- involve the individual, following best practice guidelines when making a decision, (See 5.4.6) and, if appropriate, involve relevant others in the discussion
- communicate the decision to other health and social care providers
- review the decision if necessary.

4.7.2 A registered nurse making DNACPR decisions must:
- be competent to make the decision
- document the decision (See 5.7)
- involve the individual, following best practice guidelines when making a decision, (See 5.4.6) and, if appropriate, involve relevant others in the discussion
- communicate the decision to other health and social care providers
- review the decision if necessary.

4.8 Health and Social Care Staff delivering care must:
- adhere to the policy and procedure
- 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
• notify other services of the DNACPR decision or an ADRT on the transfer of a person
• participate in the audit process.

4.9 **Commissioners and Commissioned Services must:**
• ensure that services commissioned implement and adhere to the policy and procedure
• ensure that pharmacists, dentists and others in similar healthcare occupations are aware of this policy.

4.10 **Within applicable organisations In-patient Specialist Palliative Care staff must:**
• include information regarding a DNACPR decision in pre-admission documentation
• cascade all decisions to staff
• adhere to the policy and procedure
• notify line manager of any training needs
• ensure they are aware of the existence of a DNACPR decision or an ADRT, either via the individual / relatives or the healthcare professional requesting assistance
• check the validity of any decision
• participate in the audit process.

5  **Do Not Attempt Cardio Pulmonary Resuscitation**

5.1 **Purpose**

5.1.2 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.
• Are compliant with the relevant legislation and case law

5.1.3 This policy will provide clear guidance for clinical staff.

5.1.4 This policy will ensure that DNACPR decisions refer only to CPR and not to any other aspect individual’s care or treatment options.

5.2 **Legislation**

5.2.1 Under the Mental Capacity Act (2005), health & 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.

5.2.2 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).

5.2.3 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 but must always report when the deceased has died a violent or unnatural death, the cause of
death is unknown, or the deceased died while in custody or otherwise in state detention.

**For more information see:**

5.3 Guidance

The Resuscitation Council (UK):

- Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009, updated 2015)
- Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (3rd edition October 2014).
- Decisions Relating to Cardiopulmonary Resuscitation [https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/](https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/)

5.4 Process

5.4.1 For the majority of 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.

5.4.2 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 decision or an valid and applicable ADRT is in place and made known
- a suitably empowered LPA is present at the point of the arrest, this individual will then make the decision regarding commencement of CPR
- there is clear evidence of a recent verbal refusal of CPR as this needs to be considered when making a best interests decision.

5.4.3 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
- 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.

5.4.4 In the event of registered 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?
• Is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interests decision on behalf of the patient.

• Provided the registered health care staff has demonstrated rationale for their decision making, the employing organisation will support the member of staff if this decision is challenged.

5.4.5 When considering making a DNACPR decision for an individual it is important to consider the following:

• Is Cardiac Arrest (CA) a clear possibility for this individual? If not, it may not be necessary to go any further.

• If CA is a clear possibility for the individual, and CPR maybe successful, will it be followed by a length and quality of life that would not be of overall benefit to the person? The person’s views and wishes in this situation are essential and must be respected. If the person lacks capacity, a registered health and welfare LPA will make the decision. If a registered health and welfare LPA has not been appointed a best interests decision will be made.

• If the individual has an irreversible condition where death is the likely outcome, the individual should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual.

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

• the DNACPR decision is made following discussion with patient/others, this must be documented in their notes.

• the DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this, then a discussion with relatives/carers should only take place with the person’s permission.

• If a discussion with a person with capacity regarding DNACPR is deemed inappropriate by medical staff, this must be clearly documented in their notes.

• the DNACPR information leaflet (See Appendix 2) should be made available where appropriate to individuals and their relatives or carers. It is the responsibility of each individual organisation to ensure that different formats and languages can be made available.

5.5 Discharge/Transfer process

5.5.1 Prior to discharge, the person, or relevant other if the person lacks capacity, **MUST** be informed of the decision. If the person is competent 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 discussion with family members.

If such discussion is likely to cause undue distress then it is usually impossible to place a DNACPR form in the person’s home until further discussions have taken place.

5.5.2 When transferring the person between settings all staff involved in the transfer of care of a person need to ensure that:

• the receiving institution 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 members 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.

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), the 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 settings and home should be informed of, and abide by, the DNACPR decision.

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

5.6 Cross Boundaries: A patient may be discharged from an institution that does not use the SofE(C) SHA DNACPR form (e.g. ReSPECT 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. This document does not require duplication onto a unified Do Not Attempt Cardio Pulmonary Resuscitation (uDNACPR) form.

For example; a patient who has a ReSPECT form, with the box stating ‘CPR attempts not recommended’ signed by the appropriate clinician, should not be resuscitated in the event of a cardiac arrest unless there is an acute, unforeseen but immediately life threatening situation as per section 5.11.2 This decision will be recognised by health and social care staff and a uDNACPR form does not need to be completed. See appendix 10 for flowchart to guide the cross boundaries process.

5.7 Documenting and communicating the decision.

Once the decision has been made, it must be recorded on the SofE(C) SHA approved DNACPR form (see appendix two) and written in the person’s notes. The LILAC form must stay with the person at all times.

- 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. 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.
- 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.
- 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 located 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.

https://www.lions105d.org.uk/projects/miab.html

**Please note:**

- Where the form has been initiated in another institution it will only be the lilac copy that will be in the front of the care notes.
- If using an electronic SofE(C) SHA 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 using the SofE(C) SHA DNACPR pad ensure that the lilac copy remains with the person and the white copy is retained for audit purposes.
- 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 in the individual's notes, additionally these can be recorded in care records, care plans etc.

5.7.1 **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, and their views on involving family and friends are not known clinicians 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.

5.7.2 It is the health care staff's responsibility to ensure communication of the form. The use of an end of life care register is recommended to ensure communication of the decision across settings. It is recommended where the person is at home, the ambulance service is informed, using their warning flag procedure.

5.8 **Review of DNACPR Decision**

5.8.1 This decision will be regarded as ‘indefinite’ unless:

- a definite review date is specified
- there are changes in the person’s condition
- their expressed wishes change where a 1b & 1c decision is concerned

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.

5.8.2 It is important to note that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR decision is reviewed, the clinician must consider whether the person can contribute to the decision-making process each time. 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.
5.9 Situations where there is lack of agreement

5.9.1 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 medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write a valid and applicable ADRT. A valid and applicable ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the valid and applicable ADRT but it is not essential.

Please note if the person had capacity prior to arrest, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. 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 valid and applicable 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)

5.9.2 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 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.

5.9.3 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

5.10 Cancellation of a DNACPR Decision

5.10.1 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 staff. The cancelled form is to be retained in the person’s notes. It is the responsibility of the health care staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision.

5.10.2 Electronic versions of the DNACPR decision must be cancelled with two diagonal lines and the word ‘CANCELLED’ typed between them, dated, signed and name printed by the health care staff.

5.10.3 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 dealing with the person, MUST inform the ambulance service that cancellation or death has occurred.

5.11 Suspension of DNACPR Decision

5.11.1 Uncommonly, some patients for whom a DNACPR decision has been established may develop CA from a readily reversible cause. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.
5.11.2 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.

5.11.3 Pre-planned: Some procedures could precipitate a CA, 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 person if appropriate, will need to take place.

6 Training Requirements

6.1 All professionally registered healthcare providers should have completed regular resuscitation training (either Basic Life Support or Immediate Life Support) and will therefore have received DNACPR awareness as part of the resuscitation training programme. Further awareness of this policy can also be obtained during one of the courses listed in section 6.2 of this policy.

6.2 The awareness of this policy will be raised by staff attending any one of a number of Trust provided training programmes as listed below:

- Basic Life Support (BLS)
- Immediate Life Support (ILS)
- End of Life Care
- Verification of Death

7 Monitoring Compliance

7.1 The Trust will measure, monitor and evaluate compliance with this policy through audit and data collection.

7.2 The Trust 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 Trust 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 (see Appendix 3 audit tool)

7.3 Frequency and information.

- Compliance with the policy will be audited annually using the agreed Trust /DNACPR Audit Tool (see appendix four)
- Local leads will decide number of DNACPR forms will be examined.
- All institutions need to store the audit copy of the DNACPR form so that it is easily accessible when the local lead requests the information.
7.4 Information will be used for future planning, identification of training needs and for policy review.

8. **Policy Review**

Southern Health NHS Foundation Trust will lead the review of unified DNACPR Policy. The Trust policy will be reviewed to determine its effectiveness and appropriateness and any amendments agreed by the resuscitation and medical emergencies group.

9. **Associated Documents**

This policy should be read in conjunction with the following documents;
- Medical Emergencies and Resuscitation Policy
- Care of a Patient after their Death Policy
- Palliative Care Handbook

10. **Supporting References**

Advance Decisions to Refuse Treatment, a guide for health and social care professionals.
London: Department of Health
[Accessed 03-06-2009, updated 2013]

Coroners Act 1988 (c. 13) [Accessed 12/10/2009]


http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1

NHS End of Life Care Programme & the National Council for Palliative Care (2008)

Resuscitation Council UK (October 2014, revised 2016) Decisions relating to cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, RC (UK)
https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

https://www.rcplondon.ac.uk/guidelines-policy/advance-care-planning

Recommended Summary Plan for Emergency Care and Treatment
http://www.respectprocess.org.uk/
Appendix 1
**UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (uDNACPR)**

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.southengland.nhs.uk/wp-content/uploads/2012/DNACPR/toolkit-v5.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 patient’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 “CANCELLLED” written clearly between them, signed and dated by the healthcare staff. It is the responsibility of the healthcare staff cancelling theDNACPR decision to communicate this to all parties informed of the original decision (see section 4.0 on form).
- Electronic form must be printed and signed on A4 paper and copies kept for audit purposes and notes.
- Triplicate forms, keep together until person is discharged/dies or decision is cancelled. Carbon 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.**

<table>
<thead>
<tr>
<th>1.</th>
<th>Reason for DNACPR decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.A</td>
<td>CPR is unlikely to be successful</td>
</tr>
<tr>
<td></td>
<td>Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person’s best interest. 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.</td>
</tr>
</tbody>
</table>

| 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 a 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 if 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 LoC, ordering new DNACPR forms, for the policy or for the electronic form access: http://www.southengland.nhs.uk/what-we-do/one-of-life-care/central-area-documents

Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR)
Version 4
July 2018
Appendix 2

Adult Information Leaflet

Leaflet contents

This leaflet explains:

What cardiopulmonary resuscitation (CPR) is.

How you will know whether it is relevant to you.

How decisions about it are made.

It 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 other staff) caring for you.

A DNACPR decision is about cardiopulmonary resuscitation only and you will receive all the other treatments 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 left there is a chance it will work. For example, if a person has a serious injury or suffers a heart attack and their 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.

What if a person has expressed his/her wishes not to have CPR, must the doctor/other relevant staff do CPR?

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 others cannot make this 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 patient’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 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.
Leaflet contents continued

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 (for example, heart disease or diabetes)
- The overall condition of your heart.

When CPR is attempted in hospital it is successful in restarting the heart and breathing in about 4 out of 10 patients. On average, 2 out of 10 patients survive long enough to leave hospital. The figures are much lower for people with serious underlying conditions or for those not in hospital.

Everybody is different and the healthcare team will explain what CPR may do for you.

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. Age alone does not affect the decision, nor do 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, whether it is likely to improve your quality of life, and whether you will be left with a good quality of life. 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.

Leaflet, 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 see the Mental Capacity Act (MCA) and the Health and Social Care Act 2008.

If you have appointed a person with a formal care plan (CWI), they may be able to consent on your behalf in certain situations if approached.

If it is decided that CPR will not 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 about the decision. There will be a note in your medical records that you are not for cardiopulmonary resuscitation. This is called a "do not attempt cardiopulmonary resuscitation" or DNACPR decision.

What if I don't want to decide?

You don't have to talk to the healthcare team if you don't want to, or you can put through a lot. You may want to talk to the healthcare team if you feel you are being asked to decide too quickly. Your family, close friends, or those who you feel know you best might be able to help you make a decision you are comfortable with. Otherwise, the healthcare team 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 case 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 for do not want to be consulted you should let your 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 will follow your wishes. You can make an Advanced Decision to Refuse Treatment (ADRT) formally 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 a written document signed by someone else or recorded in healthcare notes
- be signed and witnessed
- 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 change my mind?

You can change your mind at any time, and talk to any of the healthcare team caring for you. If you are still not comfortable with the decision you have made, 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 do I talk to about this?

If you need to talk about this with someone outside of your family, friends or care, to help you decide what you want, you may find it helpful to contact any of the following:
- Counselling
- Independent Advocacy Services
- Patient Advice and Liaison Services (PALS)
- Patient Support Services
- Spiritual care, such as a chaplain.

Please leave local contact details in the box.

Adapted from: "Decisions about cardiopulmonary resuscitation model patient information leaflet, Resuscitation Council (UK), April 2009.

Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR)
Version 4
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## Appendix 3 – Policy Audit Tool

**DATE:**……………………  **LOCATION:**……………………………………  **WARD MANAGER:**……………………………………  **SERVICE:**……………………………………

**PERSON CARRYING OUT AUDIT:**……………………………..

**UDNACPR FORM**

<table>
<thead>
<tr>
<th>DNA CPR Form Question</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
<th>Comments (for e.g. no address, illegible, what’s missing? If no, why? etc)</th>
<th>Guidance notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Are there clear patient details?</td>
<td></td>
<td></td>
<td></td>
<td>Record reason for ‘No’ answer or ‘Not recorded’ answer clearly in comments box. E.g. illegible, omitted, only partially completed</td>
<td></td>
</tr>
<tr>
<td>2 Is the date of DNACPR decision completed?</td>
<td></td>
<td></td>
<td></td>
<td>Record reason for ‘No’ answer or ‘Not recorded’ answer clearly in comments box. E.g. illegible, omitted, only partially completed</td>
<td></td>
</tr>
<tr>
<td>3 What reason for DNACPR decision has been completed?</td>
<td>1a</td>
<td></td>
<td></td>
<td>Tick the reason for decision, 1a, 1b or 1c in the ‘Yes’ box.</td>
<td></td>
</tr>
<tr>
<td>4 Has more than 1 reason been ticked?</td>
<td></td>
<td></td>
<td></td>
<td>If ‘Yes’ please state clearly in the comments box which combinations have been ticked. e.g. 1a and 1b, or 1a and 1c, have been ticked.</td>
<td></td>
</tr>
<tr>
<td>5 If section 1a has been ticked, is there CLEAR and APPROPRIATE information regarding why the decision has been made?</td>
<td></td>
<td></td>
<td></td>
<td>If the answer is ‘No’ or ‘Not recorded’ (there is NOT clear and appropriate information) please be specific in the comments as to the reason. E.g. Old or frail is not</td>
<td></td>
</tr>
</tbody>
</table>
### 6 Has the person been informed of the decision?

This is to be completed for 1a and 1b decisions. If a reason has been given for not discussing with the person please write this in the comments box.

### 7 If the person has not been informed has a relevant other?

If the answer is ‘No’ and the reason has been given, please write this in the comments box.

### 8 Who has made the decision?

Tick in the ‘Yes’ box against the person making the decision in Section 2 of the form. If the decision has been made by ‘Other’ please state who in comments box.

#### Other

#### 10 Is the record clearly dated, timed and signed correctly?

If ‘No’ or ‘Not recorded’ please give details in comments box.

#### 11 Has the decision been verified within 48 hours (Acute Trusts Only), if appropriate?

If ‘No’ answer, give details, e.g. not verified, or verified out of the time scales. If verified out of timescales state how long verification took in comments box.

#### 12 Have the following sections been completed?

This question is for information only. For each section that has been completed please document. If sections are illegible or incomplete please document this and write specifics in the comments box. E.g. if section 5c has been completed but not section 5e

**Section 3 - Review**

**Section 4 - Who has been informed**

**Section 5 – other important information**
<table>
<thead>
<tr>
<th><strong>Person’s Notes</strong></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
<th>Comments (If no or not recorded, why?)</th>
<th>Guidance notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Was the form initiated in your organisation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the decision documented in the person’s notes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Are the notes clearly dated, timed and signed correctly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>Is there evidence of discussion?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4b</td>
<td>Who was it discussed with?</td>
<td>Person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevant other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4c</td>
<td>If there is no evidence of discussion, is there evidence of why decision was not discussed with the person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is there evidence since the DNACPR decision has been made, that CPR has been carried out?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Is there evidence of a mental capacity assessment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Guidance notes**
  - If ‘No’ write in comments box details, e.g. illegible, data missing.
  - If the decision has been discussed with someone other than the person or relevant other, e.g. IMCA, please document in comments box.
  - State reason for not discussing in comments box.
  - If the answer is yes, please give details in the comments box.
  - Please note: Mental Capacity assessments are only carried out if there is doubt over the person’s mental capacity.
Appendix 4

Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Policy
FAQs – Frequently Asked Questions

1. Person takes the form home, but what happens if they collapse outside of home shopping for example? Unfortunately this may be a rare occasion that an inappropriate resuscitation may be carried out. It is unlikely that the person will be on their own with no significant others to inform people of the decision. As always the default to resuscitation in such rare circumstances may happen.

2. Person comes back into hospital and has left their form at home. Either ask a significant other to go home and get it (this is the preferred option) or if this is not possible write another form making sure that the old one is collected and attached to the new form.

3. How will persons be flagged up if they have a current DNACPR order when they come into ED for example? Until a joined up IT system is in place this will be via the person, SCAS, GP referring, HCP or significant others bringing in the form. Each establishment at the moment will have their own ‘flagging’ system. SCAS can be informed using the Feature Application Procedure.

4. Why was the decision made to give the person the form to take home; would it not be more straightforward to keep it in their notes? The decision belongs to the person therefore it needs to be where the person is. If the form is in the notes it will not be easily accessible to all HCP looking after that person at home. The person will decide where to keep the form at home, whether this is in the care notes in the house or in a drawer etc. the tear off slip needs to be completed and placed in the Message in Bottle (MiB) preferably by the discharge nurse. It needs to be explained to the person and relevant others the importance of not moving the MiB from the fridge door or the form from its designated place.

5. If the person has an old form and a new lilac form is completed, what happens to the old form? The old forms need to be replaced so as not to cause confusion. The form can be written out and the doctor can sign it on their next visit as the decision is already there. Cross the old form with 2 diagonal lines and write clearly between the lines ‘Transferred to new documentation.’. If the person is discharged home change to the new documentation prior to discharge. The old form should be kept in the back of the notes NOT the front.

6. How can we flag electronically? At present each individual Trust needs to do this within their system and inform other institutions so they can do theirs. Some trusts have ‘bedman’ for example.

7. How do we put on the electronic discharge letter to GP? Contact the person responsible for the discharge paperwork within your Trust and ask them to add it if it is not there already. This is part of the Trusts KPI’s now so needs to be addressed if it has not already been done. In the meantime it can be typed manually in the free text.
8. What happens if the consultant / GP refuses to write these forms even if they agree resus would be futile / inappropriate? If they point blankly refuse to partake in such decision making this could be classed as a ‘blanket ban’ and this is not legally allowed as these decisions are individual to each person. If the person is likely to die, CPR will not be successful etc. (see decision-making framework) then it is a breach of policy for them to ignore it (the Trust has adopted the policy, policy is not the same as guidance it has more standing). A second opinion could be sought from another consultant / GP so that a DNACPR decision can be written. If the person is asking for this decision and it is refused they are within their rights to seek a second opinion / legal advice.

9. If suspended for example pre-planned surgery, do Drs write a completely new form on return from theatre? It will be very rare that a DNACPR will be suspended; this is usually only done in cardiac theatres etc. What we do not want is every surgeon cancelling every DNACPR decision because the person goes to theatre. This decision needs to be on an individual basis taking into account their co-morbidities. If going to surgery, the decision needs to be discussed with the person whether to suspend or not. It is an individual decision. If the decision is taken to suspend, there is no formal suggestion of how to do this however one suggestion is to Cross the form with 2 diagonal lines and write clearly between the lines ‘suspended for ……………’ sign and date it. Write a new form when the suspension ends.

10. Very few staff have heard of message in a bottle (MiB). This is not unusual in an acute trust or other areas that have not used them in the past; however it is our job now to raise awareness.

11. Why is the form not kept in the bottle? It is a carbonated copy; if it is folded and unfolded several times the folds may become unreadable. When a person goes home several people may need to access the information in the MiB. Remember only the tear of slip stating where the form is to be kept is placed in the MiB.

12. Whose responsibility is it to inform all other carers on discharge? The discharging department / ward need to inform any carers that will be helping the person. So if you know a GP, district Nurse, health and social carers’ are needed they need to be informed.

13. The form may be easily damaged when taken home/mislaid/lost- would it be a good idea to have a lilac envelope in which to store it? No if the form is placed in the front of notes or in a clear plastic wallet if not in the notes it will be easily seen in an emergency.

14. Which nurses in the future will be trained to write a DNACPR decision? Some senior specialist nurses such as palliative nurse specialist, heart failure nurse, respiratory nurse etc. It has not been decided yet as competencies etc. need to be written.

15. What if an error is made during completion of the form? Cross the form with 2 diagonal lines and write clearly between the lines ‘Void due to error,’ do not discard as it is important for audit. Keep both copies in the pad.

16. Would it be better to have 3 copies instead of 2? 1 for audit, 1 for notes and 1 to go home with person. This suggestion has been passed on to relevant working party. A third copy was discussed in the form working group and because of the problems of carbonated paper not going through to the third layer, unless the person pressed hard it was decided on the two copies. It is something that will be considered again once the electronic form is ready / when the policy is reviewed. If you make a copy of the form for the notes please cross the form with 2 diagonal lines and write clearly between the lines ‘COPY.’
17. If the person is going home but the consultant has not discussed the DNACPR decision with the person as it has been felt that it was not in their best interest to discuss, can the lilac form stay in the notes? We are not anticipating that all persons with a DNACPR form in hospital will be transferred out of hospital with the form in place. This practice will be infrequent at first and may gradually increase as staff feel more comfortable and confident with the process. Those persons in whom that should be considered will very much be at the discretion of their clinical team. If they feel that would be desirable it should trigger further sensitive conversation with the person and family to seek their understanding about the DNACPR form and their consent for it to be transferred to the community setting. The form cannot be transferred to the community without the person’s knowledge and documented verbal consent. If the person does not have capacity to support this communication then that should occur through their representatives (e.g. relevant others). Once a decision has been made to transfer the information then this must be communicated to relevant staff in the community at the time of discharge both included in written/electronic discharge proforma and also by telephone to the GP in particular, but also ideally to district nurse/home staff if involved in that person’s care.

18. Who informs the Ambulance service? SCAS have a ‘Feature Application Policy’ that allows the flagging of clinical conditions. Work is ongoing to aide communication links. If you are discharging a person inform SCAS that a DNACPR decision is current and they will flag this on their system. If an ambulance is transferring the person home ensure section 5 is completed.

19. If the person has a DNACPR order and then has a procedure e.g. sedation and subsequently collapses as a result of the procedure, is the order suspended? This would be an individual decision depending on the person and what had been discussed with them prior to the procedure, but on the whole emergencies that can be addressed immediately can equal temporary suspension of DNACPR decision. Again this is a very rare occurrence and should not be at the forefront of our teaching.

20. If the person is very deaf it makes a discussion about DNACPR extremely unproductive and certainly not in confidence. Any suggestions? Take the person to a private room, with their working hearing aids, someone who signs if necessary and their relevant others. The patient information leaflet is an adjunct to the discussions.

21. With regards to the indefinite review date, can we write ‘on discharge’? We need to stress that a review is not always necessary, again this will be fairly rare. Reviews need to be dated otherwise they are in breach of policy; ‘on discharge’ is not acceptable. Reviewing should happen for clinical reasons or person changing their decision and not because of discharge. Cancelling a decision just because of discharge is not acceptable.

22. If person is readmitted under a different consultant; this consultant decides to cancel the DNACPR decision, can they do that? It is that consultant’s decision although perhaps the fact that the person has an indefinite DNACPR decision may have some influence. If the person’s clinical situation or the person’s own decision has not changed there would be no reason to cancel the DNACPR decision. Having a different doctor in charge of a person’s care should not be a reason to cancel.

23. A person is admitted with a psychotic episode, they bring their DNACPR form with them (decision made for medical reasons not their mental health disease). If during their stay the person attempts to hang themselves would the staff suspend the order and attempt resuscitation? In normal psychotic episodes if attempted suicide happens they would always attempt resuscitation. This wasn't the anticipated situation when the DNACPR decision was made and every reasonable attempt should be made to
resuscitate the individual in this situation. If later sued the defence would be that staff acted in the individual’s best interests at the time, the DNACPR form was not completed with the eventuality of suicide in mind.

**Comments**

1. ‘Despite some misgivings from staff about the new policy they were reassured that it’s all based on current legislation, aiming for good practice. Although they recognised that change takes time and feedback about what works and what doesn’t is definitely welcomed.’

2. ‘The small print at the top of the lilac form saying that “all other appropriate care should be carried out” should have been in bold capital letters.’ This will be discussed when the policy is reviewed.

3. ‘Up until now the Trust has not had a clear policy and pathway for DNACPR orders; this policy’s aim will make it clearer and easier for staff.’

4. The forms should be numbered to aid record keeping and security. Yes already noted and working on this for any further pads which are ordered.

5. ‘This will be an improvement on the system. If GPs work with nursing homes in improving decision making, this may reduce the number of admissions for which is often not in the person’s best interest.’
Appendix 5 - LEaD (Leadership, Education & Development) Training Needs Analysis

Please see the Training Needs Analysis for Appendix 1 of the Medical Emergencies & Resuscitation Policy
Equality Impact Assessment (or ’Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team

<table>
<thead>
<tr>
<th>Name of policy/service/project/plan:</th>
<th>Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Number:</td>
<td>SH CP 31</td>
</tr>
<tr>
<td>Department:</td>
<td></td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Simon Johnson Resuscitation Officer</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>15 June 2012</td>
</tr>
</tbody>
</table>

1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe purpose of the policy including</td>
<td>The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service ensuring a consistent approach is applied in relation to the management of cardiopulmonary resuscitation and medical emergencies across the Trust.</td>
</tr>
<tr>
<td>How the policy is delivered and by whom</td>
<td></td>
</tr>
<tr>
<td>Intended outcomes</td>
<td></td>
</tr>
</tbody>
</table>

This Medical Emergency and Resuscitation policy is based on the recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) (2004, updated 2008) and has been developed to describe the process for managing and mitigating risks associated with resuscitation, as detailed in the current NHSLA Risk Management Standards, the NICE Guidance, The ECT Handbook 2nd Edition, Royal College of Psychiatrists (2004) and the Mental Health Act.
### 2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent research findings (local and national)
- Results from consultation or engagement you have undertaken
- Service user monitoring data
- Information from relevant groups or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or complaints or compliments about them
- Recommendations of external inspections or audit reports

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong></td>
<td></td>
</tr>
<tr>
<td>What is the equalities profile of the team delivering the service/policy?</td>
<td>The Equality and Diversity team will report on Workforce data on an annual basis.</td>
</tr>
<tr>
<td><strong>2.2</strong></td>
<td></td>
</tr>
<tr>
<td>What equalities training have staff received?</td>
<td>All Trust staff have a requirement to undertake Equality and Diversity training as part of Corporate Induction (Respect and Values) and E-Assessment</td>
</tr>
<tr>
<td><strong>2.3</strong></td>
<td></td>
</tr>
<tr>
<td>What is the equalities profile of service users?</td>
<td>The Trust Equality and Diversity team report on Trust patient equality data profiling on an annual basis</td>
</tr>
<tr>
<td><strong>2.4</strong></td>
<td></td>
</tr>
<tr>
<td>What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?</td>
<td>The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives</td>
</tr>
</tbody>
</table>

**Key Research:**

- Resuscitation Group, Mental Capacity Act Resuscitation Council (UK) (2010)
that include:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership

<table>
<thead>
<tr>
<th>2.5</th>
<th>What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations</td>
</tr>
</tbody>
</table>

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this.
<table>
<thead>
<tr>
<th>Positive impact (including examples of what the policy/service has done to promote equality)</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong>&lt;br&gt;This policy applies to all ages&lt;br&gt;A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings across all ages</td>
<td>Age Concern warned that the UK's elderly feared they were at risk of not being revived simply because of their age&lt;br&gt;The balance may not always correctly be struck between recognising parental responsibilities, children's rights and patient's best interests, in consideration of do not resuscitate orders for children.</td>
<td><strong>Actions to overcome problem/barrier</strong>&lt;br&gt;Old age alone should not be a criterion in deciding on a do not resuscitate order.&lt;br&gt;The wishes taken by competent children should be respected, that parents can consent to treatment for children up to the age of 16 and that advice should be sought where treatment deemed appropriate is refused by the patient or parents. <strong>Resources required</strong>&lt;br&gt;DNAR Data audit: <strong>Responsibility</strong>&lt;br&gt;<strong>Target date</strong></td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>The Trust will respond positively to requests of information in alternative formats to ensure information is understood by all patients and staff</td>
<td>Patient’s/carer’s having low vision may not be able to see/read the patient information leaflets about Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>A key component of this policy is the communication</td>
<td>No negative impacts identified at this stage of screening</td>
</tr>
</tbody>
</table>

Incidents will be reported using the Trust approved incident reporting procedure.
<p>| Reassignment | between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings across all protected groups |  |  |  |
| Marriage and Civil Partnership | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings | No negative impacts identified at this stage of screening |  |  |
| Pregnancy and Maternity | Effective resuscitation of the mother will provide effective resuscitation for the foetus. | Foetuses may suffer, if pregnant patients who suffer cardiac arrest are not given obstetric care. There are a multitude of physiological and anatomical changes during pregnancy that may influence the | Consideration of individual care plans |  |  |</p>
<table>
<thead>
<tr>
<th>Race</th>
<th>A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making</th>
<th>A patient's first language may not be English and may require information in alternative formats or access to an interpreter</th>
<th>Interpreting and Translation: Access to Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>management of the pregnant patient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cardiac Output increases by 20-30% in the first 10 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The average maternal heart rate increases by 10-15 beats per minute</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Both systolic and diastolic blood pressure fall, on average by 10-15mmHg</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religion or Belief</strong></td>
<td>The Trust has a Medical Emergency &amp; Resuscitation policy which should be read in conjunction with this policy to ensure that CPR is only initiated for patients when it is appropriate and in their best interests. It is the responsibility of each member of the multidisciplinary team to know whether a patient is for CPR or not. All teams within the Trust should establish a process to ensure this responsibility is recognised. <strong>If there is any doubt about the CPR status of an individual, resuscitation should be commenced.</strong></td>
<td>Policy applies to all regardless of religion or belief unless an advance decision or DNR is in place.</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>A key component of this policy is the communication between professional,</td>
<td></td>
<td></td>
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</table>

Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR) Version 4 July 2018
| **Sexual Orientation** | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings for lesbian, gay and bisexual people | No negative impacts identified at this stage of screening |
Appendix 7 - Policy Implementation Plan

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Policy Author:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy</td>
<td>Resuscitation Officer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action to be taken</th>
<th>By who</th>
<th>By when</th>
<th>Progress to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing awareness of the policy will be raised during</td>
<td>Resuscitation Officers/Trainers</td>
<td>During mandatory training</td>
<td>ongoing</td>
</tr>
<tr>
<td>• Basic Life Support Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immediate Life Support Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Updates to policy or procedure to be discussed during the End of Life Committee</td>
<td>Resuscitation Officer Committee members</td>
<td>Standing agenda item - resuscitation committee</td>
<td>ongoing</td>
</tr>
<tr>
<td>meetings and resuscitation committee</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 8 – flow chart guide to fill in a uDNACPR form

Flow chart guide to fill in a uDNACPR form

1. Complete demographics section (Full name, address, date of birth, and NHS/hospital number)
2. Complete date of decision and institution name
3. Reason for DNACPR decision
4. Document reason that CPR is likely to be unsuccessful
5. Discuss decision with patient if appropriate. If not document reason
6. Undertake capacity assessment if patient lacks capacity and document in medical notes
7. Does patient have a Health & Welfare UPA?
   a. Yes
      i. Document name
   b. No
      i. Document name of person who has been involved in best interests discussion
8. Document name, date, time and signature on Section 2. Counter-sign if decision has been made by delegated professional
9. Is this decision for review?
   a. Yes
      i. Document review date
      ii. Update outcome of review
      iii. Inform the appropriate services and tick once completed
   b. No
      i. Proceed to section 4
      ii. Document any other important information in section 5

1. Place completed uDNACPR form in front of patient notes
2. Inform staff of change in resuscitation status
3. Fully document discussion and decision in medical notes
Appendix 9 – Flow chart to check a completed DNACPR form

Flow chart guide to check a completed Do Not Attempt Resuscitation Form

1. Is the form a UNIFIED DO NOT ATTEMPT RESUSCITATION FORM?
   - Yes: Check the following are all documented clearly:
     1. Full name
     2. Address
     3. Date of birth
     4. NHS/hospital number
   - No: Contact Medical Team to ensure documentation is completed

2. Check date of DNACPR decision and Institution name are documented clearly
   - Yes
   - No: Contact Medical Team to ensure documentation is completed

3. Has the reason for DNACPR been ticked (A, B, or C) and rationale documented?
   - Yes
   - No: Contact Medical Team to ensure documentation is completed

4. If reason 'C' has been ticked is a copy of the Advanced Decision to Refuse Treatment form attached to the uDNACPR form
   - Yes
   - No: Locate, photocopy and attach Advanced Decision to Refuse Treatment form

5. Has section 2 been fully completed including:
   1. Name
   2. Signature
   3. Position
   4. Date
   5. Time
   - If the form has been completed by a delegated professional has it been verified by a Consultant/GP?
     - Yes
     - No: Contact Medical Team to ensure documentation is completed

6. If sections 3, 4 and 5 have been completed, have the required fields been fully completed (review date, name, signature, outcome of review, who has been informed of the DNACPR decision)
   - Yes
   - No: Contact Medical Team to ensure documentation is completed

Ensure completed uDNACPR form is placed in the front of the patient notes
Appendix 10 – Flowchart to guide the forms associated with Resuscitation status

Flowchart to guide the forms associated with Resuscitation status

Does the patient have a ReSPECT form?

No

Yes

Is the patient for active resuscitation on the ReSPECT form?

No

Yes

The decision has been made not to attempt resuscitation in the event of a cardiac arrest

Honour the do not resuscitate decision in the event of cardiac arrest

Ensure the form is filed at the front of the patient's notes

Ensure medical notes and handover paperwork is updated

Ensure staff caring for the patient are aware of the do not resuscitate decision

Initiate resuscitation and call (0)999 ambulance in the event of cardiac arrest

Initiate resuscitation and call (0)999 ambulance in the event of cardiac arrest

‘unified DNACPR form’ or any other cross boundaries ‘Do not resuscitate document?’

No

Yes

Initiate resuscitation and call (0)999 ambulance in the event of cardiac arrest