# Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR)

## Version: 5

**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**
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.

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End Of Life Committee  
Patient Safety Group  

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**Equality Impact Assessment (for policies only)**
The Equality Impact Assessment has been completed. The assessment document is held centrally and is available by contacting policies@southernhealth.nhs.uk
Version Control

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<th>Date</th>
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</tbody>
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Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy

Purpose

This policy is an adapted version of the NHS South of England (Central) Unified DNACPR Adult Policy for use Southern Health NHS Foundation Trust (SHFT).

All clinical staff involved in Do Not Attempt Cardiopulmonary Resuscitation decisions must follow this policy. Decisions relating to cardiopulmonary resuscitation: guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing June 2016 document and the Mental Capacity Act 2005.

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

Anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest. For many people, anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

If cardiorespiratory arrest is not expected or foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.

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

Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved. There should be clear, accurate, honest and timely communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them. Agreeing broader goals of care with patients and those close to patients is an essential prerequisite to enabling each of them to understand decisions about CPR in context.

Any decision about CPR should be communicated clearly to all those involved in the patient’s care.

This policy will provide clear guidance for clinical staff and must be followed in full.

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>Scope</td>
<td>6</td>
</tr>
<tr>
<td>3.</td>
<td>Duties and responsibilities</td>
<td>6</td>
</tr>
<tr>
<td>4.</td>
<td>Do Not Attempt Cardio Pulmonary Resuscitation</td>
<td>7</td>
</tr>
<tr>
<td>4.1</td>
<td>Legislation</td>
<td>7</td>
</tr>
<tr>
<td>4.2</td>
<td>Guidance</td>
<td>8</td>
</tr>
<tr>
<td>4.3</td>
<td>Process</td>
<td>8</td>
</tr>
<tr>
<td>4.4</td>
<td>Discharge/ transfer process</td>
<td>12</td>
</tr>
<tr>
<td>4.5</td>
<td>Cross boundaries</td>
<td>13</td>
</tr>
<tr>
<td>4.6</td>
<td>Documenting and communicating the decision</td>
<td>13</td>
</tr>
<tr>
<td>4.7</td>
<td>Review of DNACPR decision</td>
<td>15</td>
</tr>
<tr>
<td>4.8</td>
<td>Situations where there is lack of agreement</td>
<td>15</td>
</tr>
<tr>
<td>4.9</td>
<td>Cancellation of a DNACPR decision</td>
<td>15</td>
</tr>
<tr>
<td>4.10</td>
<td>Suspension of a DNACPR decision</td>
<td>16</td>
</tr>
<tr>
<td>5.</td>
<td>Training requirements</td>
<td>16</td>
</tr>
<tr>
<td>6.</td>
<td>Monitoring compliance</td>
<td>17</td>
</tr>
<tr>
<td>7.</td>
<td>Document review</td>
<td>17</td>
</tr>
<tr>
<td>8.</td>
<td>Associated Trust documents</td>
<td>17</td>
</tr>
<tr>
<td>9.</td>
<td>Supporting references</td>
<td>17</td>
</tr>
<tr>
<td>10.</td>
<td>Definitions</td>
<td>18</td>
</tr>
</tbody>
</table>

### Appendices

| 1. | Unified Do not Attempt Cardio Pulmonary Resuscitation Form | 21 |
| 2. | Adult Information Leaflet | 23 |
| 3. | Frequently Asked Questions | 25 |
| 4. | Policy Implementation Plan | 28 |
| 5. | Flow Chart Guidance To Complete A UDNACPR Form | 29 |
| 6. | Flow chart guide to check a completed Do Not Attempt Resuscitation Form | 30 |
| 7. | Flowchart to guide the forms associated with Resuscitation status | 31 |
Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy

This policy is an adapted version of the NHS South of England (Central) Unified DNACPR Adult Policy for use in Southern Health NHS Foundation Trust (SHFT).

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 at the time of their 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. To minimise any confusion, it would be advisable that these patients had a DNACPR decision made and form available in place although this may not always be the case.

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, a 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 1).

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. These conversations should be documented in the patients notes.

1.9 Training will be available to enable staff to meet the requirements of this policy (see Section 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 18 years of age and over.

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 Duties / Responsibilities

3.1 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.

3.2 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 or allied health care professionals who has achieved the required competency. Registered nurses and allied healthcare professionals must complete competency based training and would be expected to be working with patients for whom DNACPR conversations are a regular occurrence i.e. frailty team, palliative care team, heart failure nurses etc. Evidence of any training must be retained by the individual.

3.3 All registered healthcare professionals involved in the DANCPR decision making process must work within their own professional code of conduct.

3.4 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.

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

3.6 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.

3.7 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.
   • ensure the decision is documented (See 4.6.1)
• involve the individual, following best practice guidelines when making a decision, where possible (See 4.6.1) and, if appropriate, involve relevant others in the discussion
• communicate the decision to other health and social care providers
• review the decision if necessary.

3.8 A registered nurse or allied healthcare professional making DNACPR decisions must:
• be competent to make the decision
• document the decision (See 4.6.1)
• involve the individual, following best practice guidelines when making a decision, (See 4.6.1) and, if appropriate, involve relevant others in the discussion
• communicate the decision to other health and social care providers
• review the decision if necessary

3.9 Health and Social Care Staff delivering care must:
• adhere to this policy
• 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.

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

4 Do Not Attempt Cardio Pulmonary Resuscitation

4.1 Legislation

4.1.1 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.

4.1.2 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).

4.1.3 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:
4.2 **Guidance**

The Resuscitation Council (UK):
- Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009, updated 2015)
- Decisions relating to Cardiopulmonary Resuscitation, Guidance from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (3rd edition, 1st Revision 2016).
- 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/)

4.3 **Process**

4.3.1 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. 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.

4.3.2 In the event of an unexpected cardiac arrest where the patients resuscitation status is unknown, CPR will take place in accordance with the current Medical Emergencies and Resuscitation Policy.

4.3.3 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, or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted cardiopulmonary resuscitation would be inappropriate.

4.3.4 When considering making a DNACPR decision for an individual it is important to consider the following:
- is cardiac arrest a clear possibility for this individual? If not, it may not be necessary to go any further.
- 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:
  - if the individual has an irreversible condition where death is the likely outcome, the individual should be allowed to die a natural death. Although this would be a medical decision, there should be presumption in favour of patient involvement and there would need to be convincing reasons not to involve the patient such as physical or psychological harm. This is a 1a decision.
  - if cardiac arrest 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? For a patient with capacity, there should be open dialogue and shared decision making between the patient and professionals, unless the patient declines such as discussion. If the person lacks capacity, a registered health and welfare LPA will speak on behalf of the patient. If a registered health and welfare LPA has not been appointed a best interests decision will be made. However, the patient or LPA cannot demand resuscitation if the medical decision is that it will not be successful. This is a 1B decision.
  - 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. This is a 1c decision.
4.3.5 CPR will not be successful and the patient has capacity (1a Decision)

4.3.5.1 Decisions about CPR may be made following consideration of a balance of benefits and burdens. 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.

4.3.5.2 The person’s 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 the decision rests with the most senior clinician (consultant/GP/ nurse/ allied healthcare professional with the appropriate training and competencies) responsible for the person’s care, but 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 need for and reasons for the decision to the patient or to those representing a patient without capacity.

4.3.5.3 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.

4.3.5.4 If a DNACPR decision is made on clear clinical grounds that CPR would not be successful the courts have stated 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 explanation, unless a patient's wish for confidentiality prevents this. There needs to be convincing reasons not to involve the patient.

4.3.5.5 Some people make it clear that they do not wish to talk about dying or to discuss their end-of-life care, including decisions relating to CPR. When such wishes are expressed they should be respected. However, over time, the patient may want to be included in discussions and therefore it would be important to review opportunities for this to happen.

4.3.5.6 There will be circumstances when giving information and explanations about CPR decisions at an early stage to a person who is seriously ill may cause harm. However, failure to make a timely DNACPR decision when CPR will not be successful will result in people receiving inappropriate CPR that they would not have wanted. Faced with such a situation, clinicians should make the DNACPR decision that is needed and record fully their reasons for not explaining it to the patient at that time, 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.

4.3.5.7 In any situation, a clinician who makes a conscientious decision not to inform a patient of a DNACPR decision, as they believe that informing the patient is likely to cause them harm, should document clearly their reasons for reaching this decision.

4.3.5.8 The DNACPR form (Appendix 1) Section 1a should be completed for a DNACPR decision where CPR will not be successful and the patient has capacity, including a record of the discussions with the person and whether the family or carers have been informed.

4.3.6 CPR will not be successful and the patient lacks capacity (1a Decision)

4.3.6.1 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.
4.3.6.2 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. Discussion with the Clinical Ethics Committee and the Trust Legal Department, if available, should be considered.

4.3.6.3 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 people to understand that the intention is to spare the patient traumatic and undignified treatment that will be of no benefit, as they are dying, not to withhold life-saving treatment, and not to withhold any other care or treatment that they need.

4.3.6.4 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 interests in order 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 decision to those close to the patient 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, in itself, meet the threshold for it being not practicable and appropriate.

4.3.6.5 The DNACPR form (Appendix 1) Section 1A) should be completed for a DNACPR decision where CPR will not be successful and the patient lacks capacity, including recording a reason why the person has not been informed and which relevant other has been informed, and if not why not.

4.3.7 Decisions about CPR that are based on a balance of benefit and burdens (1B Decision)

4.3.7.1 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 open dialogue and shared decision-making between the patient and professionals, unless the patient declines any such discussion. 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.

4.3.7.2 When recording on a DNACPR form that the reason for not informing the patient is because they lack capacity there needs to be documentation of how capacity was assessed in the medical notes. The documentation must be one of the following options:

a) Clearly writing in the medical notes that this is a Mental Capacity Act (MCA) assessment and including the following four points
1. What is the decision that needs to be made
2. What is the impairment 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 by any other means.

b) Or completing a MCA assessment form from - Hampshire Mental Capacity Toolkit

c) Or noting nothing has changed from a previous MCA assessment.

4.3.7.3 People should be informed sensitively about what CPR involves and its possible risks and adverse effects, as well as its likely chance of success in their specific circumstance, to try to help them to make informed decisions about whether or not they would want it.

Careful explanation will be needed to help them to understand that:
- cardiorespiratory arrest is part of the final stage of dying
- CPR is unlikely to be successful when someone is dying from an advanced and irreversible or incurable illness
- healthcare professionals may start CPR inappropriately when someone dies unless a DNACPR decision has been made and recorded

4.3.7.4 The DNACPR form (Appendix 1) Section 1B) should be completed for a DNACPR decision where CPR maybe successful, but followed by a length and quality of life which would not be of overall benefit to the person. This includes a record of the discussions with the person or relevant others.

4.3.8 There is an Advanced Decision to Refused Treatment (ADRT) and the patient lacks capacity (1C Decision)

4.3.8.1 CPR must not be attempted if it is contrary to a valid and applicable ADRT (in England and Wales) made when the person had capacity.

4.3.8.2 In England and Wales advance decisions are covered by the Mental Capacity Act 2005. The Act confirms that an ADRT refusing CPR will be valid, and therefore legally binding on the healthcare team, if:
- the person was 18 years old or over and had capacity when the decision was made
- the decision is in writing, signed and witnessed
- it includes a statement that the advance decision is to apply even if the person’s life is at risk
- the advance decision has not been withdrawn
- the person has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- the person has not done anything clearly inconsistent with its terms
- the circumstances that have arisen match those envisaged in the advance decision.

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

4.3.8.4 If a patient satisfies the above criteria for a ADRT, then the 1C section of the DNACPR form should be completed.
4.3.9 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. 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 Trust will support the member of staff if this decision is challenged.

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

- Where the DNACPR decision is made following discussion with patient/ others this must be documented in their notes
- where 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 the Trust to ensure that different formats and languages can be made available

4.4 Discharge/ Transfer process

4.4.1 Prior to discharge, the person, or relevant other if the person lacks capacity, MUST be informed of the decision even 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 discussion with family members.

4.4.2 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.

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

- the receiving place of care 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.
4.4.4 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.

4.5 Cross Boundaries

4.5.1 A patient may be discharged from an institution that does not use the 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.

4.5.2 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 4.10.2 This decision will be recognised by health and social care staff and a uDNACPR form does not need to be completed. See appendix 7 for flowchart to guide the cross boundaries process.

4.6 Documenting and communicating the decision.

4.6.1 Documentation

4.6.1.1 If a DNACPR decision is deemed appropriate there is a presumption that a discussion will be held between the clinician (Consultant, GP, appropriately trained registered nurse or allied healthcare professional) with the appropriate training and competencies) and the individual with the following points to be considered:

- The DNACPR decision and discussion with the individual must be recorded on the DNACPR form AND documented in the medical notes. Those using electronic patient records should document the decision and discussion in the progress notes, palliative care assessment (where applicable) and also in the appropriate alerts. Those close to the patient should also be informed and offered explanation, unless a patient’s wish for confidentiality prevents this.
- If the individual is unwilling to discuss their wishes this should be respected and the clinician leading the discussion should document their refusal. Discussion with those close to the patient may be used to guide a decision in the patient’s best interests, unless confidentiality restrictions prevent this.
- Where a patient lacks capacity, the decision should be explained to those close to the patient without delay. If this is not done immediately, the reasons why it was not practicable or appropriate must be documented.
- Any discussions with those close to the patient must be used to guide a decision in the patient’s best interests.

4.6.1.2 Once the decision has been made, it must be recorded on the DNACPR form (see appendix one) and written in the person’s notes. The LILAC copy of the form must stay with the person at all times, with the exception of inpatient areas where the form will be kept at the front of the persons notes until discharge.

- 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, 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 copy of the 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 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.
- 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 person’s notes, additionally these can be recorded in care records, care plans etc.

4.6.2 Communication

4.6.2.1 It is healthcare staff’s responsibility to ensure communication of the form. It is best practice where the person is at home, the ambulance service is informed, using their warning flag procedure as well as the GP Out Of Hours Service.

4.6.2.2 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.

4.6.2.3 The DNACPR information leaflet (see Appendix 2) should be made available, where appropriate, to individuals and their relatives or carers - DNACPR Patient Info Leaflet v2

4.6.2.4 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.

4.6.3 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.
4.7 Review of DNACPR Decision

4.7.1 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.

4.7.2 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.

4.8 Situations where there is lack of agreement

4.8.1 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 person, and possibly their relatives where the person has given express wishes to do so. 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.

4.8.2 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 a 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)

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

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

4.9 Cancellation of a DNACPR Decision

4.9.1 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.

4.9.2 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.

4.9.3 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.

4.10 Suspension of DNACPR Decision

4.10.1 Uncommonly, some patients for whom a DNACPR decision has been established may
develop cardiac arrest 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.

4.10.2 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.

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

5 Training Requirements

5.1 If any training associated with this policy forms part of the statutory and mandatory training
provision for the Trust or other training ‘required by role’ then employees will complete this
as per their role and contractual requirements. Please refer to your LEaD home page for all
your statutory, mandatory and role requirements. If training associated with this policy is a
professional and/or developmental requirement this will be identified with your line
manager.

5.2 If the policy author/s have identified a need for an element of training associated with this
policy to gain mandatory status then they must contact LEaD at
LEAD@southernhealth.nhs.uk to ensure that they complete the relevant application form
and follow the process for consideration for mandatory status and where appropriate
executive approval.

5.3 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.

5.4 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)
6 Monitoring Compliance

6.1 The Trust will measure, monitor and evaluate compliance with this policy through audit and data collection. This will be undertaken by a nominated member of the End Of Life Committee twice a year with support from the Clinical Audit team.

6.2 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. Reports will be presented at the End Of Life Committee and Resuscitation Group.

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)

6.3 Frequency and information.
- Compliance with the policy will be audited annually, as a minimum, using the agreed Trust/DNACPR Audit Tool held by the Clinical Audit Team
- The audit lead will decide number of DNACPR forms to be examined.
- The Trust needs to store the audit copy of the DNACPR form so that it is easily accessible when the audit lead requests the information.

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

7. 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 Group and End of Life Committee.

8. 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

9. 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/


Recommended Summary Plan for Emergency Care and Treatment http://www.respectprocess.org.uk/

10. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardio Pulmonary Resuscitation (CPR)</td>
<td>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.</td>
</tr>
<tr>
<td>Cardiac Arrest (CA)</td>
<td>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.</td>
</tr>
<tr>
<td>The Mental Capacity Act (2005)</td>
<td>MCA</td>
</tr>
</tbody>
</table>
| 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 writing or sign language or by any other means. |
<table>
<thead>
<tr>
<th><strong>Advance Decision to Refuse Treatment (ADRT)</strong></th>
<th>A decision by an individual who has capacity, to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA).</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Independent Mental Capacity Advocate (IMCA)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Court-appointed deputy</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Registered Healthcare Professional</strong></td>
<td>A qualified healthcare worker who is registered with a professional body (e.g. NMC, GDC, GMC, HCPC)</td>
</tr>
<tr>
<td><strong>South Central Ambulance Service NHS Trust</strong></td>
<td>SCAS</td>
</tr>
<tr>
<td><strong>Health and Social Care Staff</strong></td>
<td>Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.</td>
</tr>
<tr>
<td><strong>South of England (Central) (SoE(C)) Strategic Health Authority (SHA)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>ReSPECT</strong></td>
<td>Recommended Summary Plan for Emergency Care and Treatment. 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.</td>
</tr>
</tbody>
</table>
This form will be in a book or printed on lilac paper

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

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (uDNACPR)
In the event of cardiac or respiratory arrest no attempts at CPR will be made. All other appropriate treatment and care will be provided.

1. Reason for DNACPR decision
   - A) CPR is unlikely to be successful due to
     - The person has been informed of the decision
     - The relevant other has been informed of the decision
   - 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?
     - Person lacks mental capacity and has a legally appointed Welfare Attorney.
   - C) There is a valid advance decision to refuse CPR in the following circumstances:

2. Healthcare professional making this DNACPR decision:
   - Name
   - Position
   - Signature
   - GMC/NMC
   - Date
   - Time

3. Review: (Select ONE box only)
   - This is an indefinite decision
   - Needs reviewing
   - Outcome of review: DNACPR to continue?

4. Who has been informed of this DNACPR decision?
   - 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,

The DNACPR form is located:
UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNA CPR)

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.southeastengland.nhs.uk/wp-content/uploads/2012/DNA/ACP/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 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 "CANCELLLED" written clearly between them, signed and dated by the healthcare staff. It is the responsibility of the healthcare staff cancelling the DNA CPR 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 A4 paper and copies kept for audit purposes and notes.
- Triplicate forms, keep together until person is discharged/death 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.

<table>
<thead>
<tr>
<th>1.</th>
<th>Reason for DNA CPR decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.A</td>
<td>CPR is unlikely to be successful</td>
</tr>
<tr>
<td>1.B</td>
<td>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</td>
</tr>
<tr>
<td>1.C</td>
<td>DNA CPR is in accord with the recorded, sustained wishes of the person who is mentally competent.</td>
</tr>
</tbody>
</table>

2. Person making this DNA CPR 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 DNA CPR 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. Ceiling of treatment include where ACP is kept. Preferred place of care should be noted.

6. 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 bedside in the dining room.'

* For further information regarding LoLC, ordering new DNA CPR forms, for the policy or for the electronic form access: http://www.southeastengland.nhs.uk/what-we-do/decisions-of-life-care/central-area-documents
Appendix 2

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 someone over 18 if you are under 18 there is a separate leaflet but I may also be useful for 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 (CPR) is when 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 by hand into the windpipe.

Is CPR tried on everybody whose heart and breathing stop?
In an emergency, yes, 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 resuscitate 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 the 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 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 a 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 diseases 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.
Appendices

Leaflet contents continued

What is the chance of CPR saving me if I have a cardiopulmonary arrest?
The chance of CPR saving 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 resuscitating 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 hospitals.

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

Do I need to 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 re-start your heart and breathing with a high chance of success. If it is likely to benefit you, the decision will be made.

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 the discussion off if you feel you are being asked too quickly. Your family, close friends, carers or those who you have told you are not in hospital. This is called a “do not attempt cardiopulmonary resuscitation” order or DNACPR decision.

What if I don’t want CPR, 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 it was any real possibility of being successful. If there is doubt about CPR being able to work, 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 disabled or unable to live an independent life, you can refuse CPR. Your opinion would be sought, but you do not have to do so.

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 feel your health has improved, or if you are not happy with the discussions you have had, you can follow the normal complaints procedure. Please do not hesitate to raise questions with your healthcare team 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:

• Your GP
• Independent Advocacy Services
• Patient Advice and Liaison Services (PALS)
• Patient Support services

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

For more information on Advance Decisions, visit:
www.advdec.co.uk
www.publicguardian.gov.uk

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

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Appendix 3

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 straight forward 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 resuscitation 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 and signpost where to access the bottles and further information

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 the person’s notes or alternatively in a clear plastic wallet 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.
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/care 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.
**Appendix 4 - Policy Implementation Plan**

<table>
<thead>
<tr>
<th>Action to be taken</th>
<th>By who</th>
<th>By when</th>
<th>Progress to date</th>
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<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>Clinical Trainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immediate Life Support Training</td>
<td></td>
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<tr>
<td>• Verification of Death 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</td>
<td>Standing agenda item -</td>
<td>Ongoing</td>
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<tr>
<td>meetings and Resuscitation Group</td>
<td>Committee/Group members</td>
<td>Resuscitation Group</td>
<td></td>
</tr>
<tr>
<td>Audit of inpatient SHFT initiated uDNACPR forms</td>
<td>Audit Leads (ward based)</td>
<td>Bi-annual</td>
<td>Ongoing</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>Resuscitation Officer</td>
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SH CP 31 Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR)  
Version 5  
January 2020
Appendix 5 – flow chart guide to fill in a uDNACPR form

Flow chart guide to fill in a uDNACPR form

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 6 – Flow chart to check a completed DNACPR form

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

Yes

Is the form a valid UNIFIED DO NOT ATTEMPT RESUSCITATION FORM?

No

Contact Medical Team to review DNACPR decision and document on uDNACPR form

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

Yes

Check date of DNACPR decision and Institution name are documented clearly

No

Contact Medical Team to ensure documentation is completed

Yes

Has the reason for DNACPR been ticked (A, B or C) and rationale documented?

No

Contact Medical Team to ensure documentation is completed

Yes

If reason ‘C’ has been ticked is a copy of the Advanced Decision to Refuse Treatment form attached to the uDNACPR form

No

Locate, photocopy and attach Advanced Decision to Refuse Treatment form

Has section 7 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?

No

Contact Medical Team to ensure documentation is completed

Yes

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)

No

Contact Medical Team to ensure documentation is completed

Ensure completed uDNACPR form is placed in the front of the patient notes
Appendix 7 – 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

Is the patient for active resuscitation on the ReSPECT form?

No

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

Yes

Yes

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