

**Airedale NHS Foundation Trust
Bradford District Care Trust
Bradford Teaching Hospitals NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust
Local Care Direct
Manorlands Hospice - Sue Ryder Care
Marie Curie Hospice - Bradford**

JOINT POLICY

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

(adults and young people aged 16 years and over)

Governance arrangements:

Director Responsible:	Medical Director Bradford Teaching Hospitals NHS Foundation Trust Lead Organisation: BTHFT on behalf of the organisations named above
Name of Author:	Developed and agreed by a multi-agency working group (see appendix 1)
Target Audience:	All staff working in the organisations named on this policy.
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VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
V 7	2012	DNACPR Working Group	Archived	Superseded by V8 February 2014
V 8	2014	DNACPR Working Group	Archived	Superseded by V9 March 2015
V9	2015	DNACPR Working Group	Archived	Superseded by V10 June 2017

INTRODUCTION

- 1.1 This policy is for adults and young people aged 16 and over.
- 1.2 All healthcare organisations will routinely attempt cardiopulmonary resuscitation (CPR) on any individual in whom cardiac or respiratory function ceases, unless there is a direct order not to attempt CPR. The aim of this policy is to outline the process and associated reasons for not attempting CPR on an individual.
- 1.3 CPR could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are inevitable as part of dying and thus, theoretically, CPR could be used on every individual prior to death. It is highly desirable to identify patients for whom cardiopulmonary arrest represents the terminal event in their illness and for whom CPR is inappropriate. It is also essential to identify those patients who would not want CPR to be attempted in the event of a cardiopulmonary arrest and who competently refuse this treatment option.
- 1.4 There will be some patients for whom attempting CPR is clearly inappropriate: for example a patient in the final stages of a terminal illness where death is imminent, unavoidable and CPR would not be successful. If, exceptionally no DNACPR decision has been made, a carefully considered decision not to start CPR would be reasonable.
- 1.5 Furthermore some people may wish to make an Advance Decision or statement about treatment such as CPR stating they would not wish to receive such treatments in some future circumstances. These people should be managed in accordance with their wishes.
- 1.6 This policy is based on the guidelines produced by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing 3rd Edition 2016 Decisions relating to cardiopulmonary resuscitation. It is written with due regard for the requirements of the Mental Capacity Act [2005].
- 1.7 This policy should be read in conjunction with the relevant professional standards and guidelines including the Nursing and Midwifery Council (NMC) publication <http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/> and the General Medical Council (GMC) publication: Treatment and care towards the end of life; good practice in decision making (July 2010) and Decisions relating to cardiopulmonary resuscitation, British Medical Association, the Resuscitation council (UK) and the Royal college of Nursing 2016

2 AIM AND OBJECTIVES OF THE POLICY

- 2.1 The overall aim of this policy is to ensure that NHS staff are aware of their responsibilities in relation to DNACPR decisions and processes and are fully supported in their role so that patients receive appropriate care. In particular the policy aims to achieve a coordinated approach across the Bradford, Airedale, Wharfedale and Craven district so that the transfer of patients between services does not compromise dignity, quality of care or patient choice.
- 2.2 Specific objectives include:
 - To recommend that resuscitation decisions are made in the context of other emergency care and treatment decisions with appropriate communication
 - To make DNACPR decisions transparent and open to examination
 - To avoid inappropriate CPR attempts
 - To ensure that decisions regarding CPR are made with patient involvement where they have capacity to do so, except for rare cases where these discussions will cause the patient physical or psychological harm or they decline to discuss this
 - To ensure that any best interest decisions regarding CPR are made with the involvement of those who best know the person

- To ensure clinical staff caring for people who have communication difficulties and other vulnerable groups where DNACPR is being considered understand they must liaise appropriately with the patient's relevant others¹
- To ensure patients, relevant others and staff have information on making decisions about CPR and that they understand the process
- To encourage and facilitate open, appropriate and full discussions with patients and their relevant others (where appropriate) about CPR issues and to give some guidance on good practice in having these discussions
- To ensure that a DNACPR decision is communicated to all relevant healthcare professionals and services involved in the patient's care

Decisions should consider:

- An assessment of whether CPR could succeed
- The clinical needs of the patient
- The patient's wishes and best interests
- Current ethical principles
- Legislation such as the Human Rights Act [1998] and Mental Capacity Act [2005]

2.3 This policy should be read alongside each organisation's key documents relating to:

- Consent to examination or treatment
- The Mental Capacity Act [2005]
- Safeguarding adults
- Equality and diversity
- Communication support for patients whose first language is not English
- Safeguarding children
- Resuscitation Policy

3 SCOPE

3.1 This policy addresses issues relating to the care of adults and young people aged 16 and over in respect of DNACPR decisions.

3.2 All staff employed by the following NHS organisations are expected to comply with this policy:

- Airedale NHS Foundation Trust
- Bradford District Care Trust - Mental Health and Learning Disabilities
- Bradford District Care Trust - Community Services
- Bradford Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance NHS Trust
- Manorlands Hospice – Sue Ryder Care
- Marie Curie Hospice - Bradford

3.3 Independent primary care contractors are expected to comply with legislation, abide by the principles of this policy and support its implementation.

3.4 Staff working in independent healthcare facilities are encouraged to comply with legislation, abide by the principles of this policy and support its implementation e.g. nursing and residential homes.

¹ For the purpose of this policy, the term "relevant others" is used to describe patients' spouses, partners, same sex partners, relatives, carers (who are not acting in a paid, professional capacity), parents or legal guardians of young people, representatives, advocates, people with lasting power of attorney, independent mental capacity advocates (IMCAs) and court appointed deputies.

4 EQUALITY AND DIVERSITY

4.1 Equality Assessment Statement

This Policy was assessed in December 2017 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010. It has potential impact on:

- Age – there is evidence that DNAR decisions are made without consent². Those making these decisions need to ensure that appropriate communication takes place.
- Disability
 - Need to ensure that appropriate communication mechanisms are put in place for deaf people.
 - Concern from people with other impairments about judgements being made about the person's "quality of life", based on non-disabled norms and perceptions that some disabled people are a "burden". The decision as to whether to place a DNACPR being ultimately the decision of the healthcare professionals alone, in particular is of concern to some disabled people.
 - People with learning difficulties: There is evidence that laws to protect people with learning disabilities are being ignored by the NHS in England.³
 - People with mental health needs are recognised as being "at risk"
- Race and ethnicity – there is no data available on the breakdown by ethnicity on resuscitation and non-resuscitation. Little evidence that the language/ communication and cultural needs of Black, Asian and Minority Ethnic (BAME) patients are being met during the implementation of the policy. The policy has been changed to make explicit the need to provide appropriate, professional interpretation when discussing options. There is also evidence that some ethnic groups have different perceptions, behaviour and choice when deciding on resuscitation.⁴ There is also evidence that: "Legal implications of deciding to withhold resuscitation can be particularly difficult when the cultural background of the doctor and patient differ".⁵

It is has been found not to have impact on:

- Gender – no evidence to suggest a difference in rates of resuscitation between women and men.
- Gender reassignment – no evidence of impact
- Marriage and civil partnership – no evidence of impact
- Maternity/pregnancy– no evidence of impact
- Religion and belief – no evidence of impact although some religious belief will affect the decision to attempt or not attempt resuscitation.
- Sexual orientation

It has also been assessed to determine whether it impacts on human rights against the FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy).

This policy has been assessed in line with the Court of Appeal Judgment in Tracey v Cambridge University Hospital NHS Foundation Trust & Others 2014. This confirms that decisions regarding whether to implement a DNACPR will have a direct impact upon a patient's Article 8 Human Rights and that there is therefore a presumption in favour of patient involvement in DNACPR decisions.

² Equal dignity and worth? Older people, human rights and the healthcare system – Help the Aged 2002.

³ Death by Indifference, MENCAP 2007.

⁴ "End of life care – selected readings", Centre for Policy on Ageing 2009.

⁵ Cox et al (2003) BME Non-English Speaking Parents and family members involved in Do not attempt resuscitation decision making. A literature review for the Resuscitation Council (UK). London: Institute of Health Sciences, St Bartholomew's School of Nursing and Midwifery.

The judgement states that:

“There would need to be sufficient reasons not to involve the patient in such decisions, it is unlikely to be sufficient to exclude a patient from DNACPR decisions solely on the grounds that their involvement is likely to distress them. Equally it is not sufficient to exclude a patient from DNACPR decisions merely because the clinical view has been reached that CPR would be futile.”

“It would only be appropriate not to involve the patient in DNACPR decisions if the clinician considers that to do so is likely to cause patient to suffer physical or psychological harm.”

The policy has also been assessed in line with the high court ruling ‘Winspear Vs City Hospitals Sunderland NHSFT 2015’:

“The core principle of prior consultation before a DNACPR decision is put into place on the case file applies in cases both of capacity and absence of capacity. If it is both practicable and appropriate to consult before doing so then, in the absence of some other compelling reason against consultation, it would be procedurally flawed to proceed without consultation. It would not meet the requirements of MCA 2005 s4(7); it would accordingly not be in accordance with the law. It would be an interference with Article 8(1) that is not justified under Article 8(2).”

This assessment will be reviewed when the policy is next updated or sooner if findings from the Judicial Review require it.

5 ACCOUNTABILITIES AND RESPONSIBILITIES

- 5.1** This policy has been developed by representatives from each of the partner organisations involved (see 3.2). Whilst the policy is jointly owned, each organisation has individual responsibilities for ensuring its effective implementation.
- 5.2** Table 1, overleaf, presents an overview of accountabilities and responsibilities within each organisation.
- 5.3** All staff employed by the partner NHS organisations which have adopted this policy are responsible for ensuring it is applied in their own sphere of work.
- 5.4** As lead organisation, BTHFT are responsible for ensuring the policy is developed and reviewed. The dissemination, audit and monitoring will be the responsibility of the individual organisations as outlined in Table 1. Assurance will be gained through the BAWC DNACPR local working group (convened by the Palliative Care Managed Clinical Network).

Responsibility for making DNACPR decisions

- 5.5** In Airedale NHS Foundation Trust inpatient units and Bradford Teaching Hospitals NHS Foundation Trust a DNACPR decision can only be made by a senior doctor, consultant, speciality doctor or specialist trainee/registrar (ST3 or more senior) who has medical responsibility for that patient. The doctor must have taken the necessary steps to consult with the patient in DNACPR discussions, or be satisfied that this has been carried out by a suitable member of their team. A decision not to discuss with a patient should only be taken if such discussions are likely to cause the patient to suffer physical and/or psychological harm, or if a patient lacks capacity to understand the decision.

A DNACPR form must be completed, and signed by an appropriate senior doctor (see 5.5) before the decision is enacted.

In exceptional circumstances, such as if the senior doctor is attending another medical emergency or not on site, the form can be completed and signed by a more junior doctor or appropriately trained health care professional AFTER discussion with an appropriate senior doctor.

Details of the discussion between the medical staff and/or nursing staff and the patient regarding the DNACPR decision should be fully documented in the medical notes.

Countersignature by a consultant, speciality doctor or ST3 is required as soon as possible and definitely within 24 hours.

- 5.6** In the community, responsibility for making the DNACPR decision lies with the patient's GP or senior nurse with appropriate training and the support of their employing organisation. As in an acute setting, a DNACPR decision cannot be made unless the necessary steps to consult with the patient have been taken unless discussions are likely to cause the patient to suffer physical and/or psychological harm.
- 5.7** Subject to them having sufficient training and skills (as outlined in section 18), other health professionals may discuss CPR decisions with patients but in all cases the DNACPR form will only be enacted once signed by either the patient's GP or senior nurse (with appropriate training and the support of their employing organisation)

In all cases decisions will be made with the full involvement of the multi-disciplinary team caring for the patient and, where appropriate and possible, with the patient and/or significant others.

5.8 Every effort should be made to discuss or inform patients (or relevant others in those who lack capacity) before a decision is made. Only if the decision is urgent (eg the patient is at risk of immediate cardiopulmonary arrest) and relevant others are not contactable a senior doctor may need to make this decision before such consultation can take place. Communication with patient and relevant others should take place as soon as possible.

5.9 The wishes of patients who lack capacity to make or understand such a decision should be determined by appropriate discussion with family members/proxy decision makers in line with the principles of the Mental Capacity Act 2005 and the Mental Capacity Act Policy held by each organisation.

Table 1. An overview of accountabilities and responsibilities within each organisation.

**ANHST includes hospital*

*and community services * BDCT includes mental health services and transforming community services*

Each organisation to review

Responsibility	ANHSFT*	BDCFT*	BTHFT (lead organisation)	YAS	Bradford CCGs	AWC CCGs	MANORLANDS	MARIE CURIE HOSPICE
Lead director	Medical Director	Medical Director	Medical Director	Medical Director	Director of Quality		Medical Director	Medical Director
Lead manager	Hospital Director	General manager older people	Operational Service Manager (cancer services)	Clinical Excellence Manager	Lead Commissioner End of Life		Palliative care services manager	Nurse Manager Day Therapy
Lead clinician	Medical Director	Medical Lead Older people	Medical Director and Specialist Palliative Care	Medical Director	General Practitioner-End of Life Lead		Medical Director	Medical Director
Internal consultation on policy issues	QSOG (quality and safety operational group)	Policy lead	Division wide consultation via Resuscitation Committee	Clinical Governance Committee	Local DNACPR working group members		Clinical Governance Group	Clinical Governance Group
Dissemination	QSOG, Lead Clinicians, Nursing and Midwifery leadership groups	Policies group	Clinical Management Group, Clinical Governance Leads, Nursing and Midwifery groups	Clinical Excellence Manager via Clinical Governance Committee	All Primary Care Teams		Clinical Governance Group, Line Managers and intranet	Clinical Governance Group, Line Managers and intranet
Implementation	QSOG, Lead Clinicians, Nursing and Midwifery leadership groups	General manager older people	Specialist Palliative Care Team and Resuscitation Committee	Clinical Excellence Manager via Clinical Governance Committee	Local DNACPR working group. General Practitioner-End of Life Lead		Hospice Senior Management Team and Clinical Governance Group	Hospice Senior Management Team and Clinical Governance Group
Training	Resuscitation Officer	Medical Lead Older people	As implementation	Clinical Team Educators	n/a		Line Managers & Resuscitation Trainer	Line Managers & Resuscitation Trainer
Monitoring and evaluation	Audit department	General manager older people	Resuscitation committee	Clinical Governance Committee	n/a		Clinical Governance Group	Clinical Governance Group
Contribution to ongoing policy development	Palliative care consultant	Profession Forum/ Medical advisory group	Specialist Palliative Care Team	Clinical Excellence Manager	GP End of Life Lead		Palliative Care Consultant	Palliative Care Consultant (AD)

6 CARDIOPULMONARY RESUSCITATION: WHAT IT IS AND WHAT IT IS NOT

- 6.1** Cardiopulmonary resuscitation (CPR) measures include external chest compression, artificial respiration and defibrillation. These measures are normally instituted by local staff and should precipitate an emergency call and other active CPR measures. CPR is instituted immediately and in full following an unexpected collapse if there is a realistic expectation of it being successful.
- 6.2** CPR measures do not include analgesia, antibiotics, drugs for symptom control, feeding or hydration (by any route), investigation and treatment of a reversible condition, seizure control, suction, and treatment for choking.
- 6.3** It is crucial to note that a DNACPR order DOES NOT MEAN that other appropriate and sometimes invasive treatments are withheld. For example, a patient with advanced gastric cancer who has a DNACPR decision may appropriately require a blood transfusion in the event of a life-threatening haematemesis or intravenous antibiotics for an infection.

7 MEDICAL PREDICTION OF THE OUTCOME OF RESUSCITATION

- 7.1** Unfortunately many people have unrealistic expectations of the success of CPR and its consequences. Explanations of the probability of survival to discharge may influence the CPR choices of patients.
- 7.2** The most recent National Cardiac Arrest Audit 2015/16 showed an initial survival rate of 49%. Overall survival to discharge was 19% ,for those with a shockable rhythm survival to discharge was 50% but in all others only 10% survive to discharge (See Ref). Features associated with almost no chance of success are pneumonia, poor mobility, advanced cancer with associated impairment of organ function, renal failure and hypotension. The most successful CPR attempts are those which involve acute respiratory failure or the prompt treatment of ventricular arrhythmias.
- 7.3** Medical prediction of the outcome of CPR should be as realistic as possible and take into account the clinical condition of the patient and the likely cause of the anticipated arrest.
- 7.4** Whilst underlying medical condition(s) may be treatable and CPR may be able to restart the heart, the sequelae of the cardiorespiratory arrest are often significant. Irrespective of prior health status, cardiorespiratory arrest can result in global ischaemic damage with the risk of hypoxic encephalopathy, renal failure, liver failure and myocardial damage. Unfortunately the degree of organ impairment may only be obvious post-arrest, however certain conditions may predispose to post-arrest organ dysfunction. For example, an increased risk of hypoxic encephalopathy in the presence of severe carotid atherosclerosis.
- 7.5** CPR should not generally be offered where the pre-arrest condition of the patient is such that intensive care unit admission would not have been deemed appropriate had the patient been referred for an ICU opinion pre-arrest. Many patients who suffer cardiorespiratory arrest will require intensive care support following successful resuscitation. However, standard admission criteria may mean that ICU admission is not appropriate based on prior health status and/or post-arrest condition. Specifically, just because the heart has been restarted ICU admission is not mandatory or even appropriate.

8 PRINCIPLES UNDERLYING THIS POLICY

This policy is based on the following principles:

8.1 Decisions regarding resuscitation are best made in the context of discussions about all relevant emergency care and treatment plans. This involves clear, appropriate and sensitive discussions with patients and relevant other about their current and likely future health status.

8.2 Circumstances of cardio-pulmonary arrest

If the circumstances of a cardiopulmonary arrest cannot be anticipated (ie It seems unlikely that circumstances would occur where the patient would require CPR) it is not possible to make a DNACPR decision that can have any validity in guiding the clinical team.

In order to make an informed decision about the likely outcome of CPR, it is essential to be able to think through the likely circumstance(s) in which it might happen for the patient. It is an unnecessary and cruel burden to ask patients or relevant others about CPR when it seems unlikely that circumstances would occur where the patient would require CPR. This should never prevent discussions about CPR issues with the patient if they wish.

Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored

8.3 Communication

Throughout their care, the patient should be given as much information as they wish about their situation including information about CPR.

Open and honest communication using clear and unambiguous language with additional written information is essential.

Where English is not the person's first or preferred language they must be offered a suitably qualified independent interpreter (refer to organisation's policy). This should include offering British Sign Language or lip speaking.

Using an independent interpreter will help to overcome communication difficulties, avoid misunderstandings and help to ensure that everyone receives the same access to information, are treated with fairly, equally and with respect.

It is inappropriate to ask or allow family or friends to interpret for them during such sensitive discussions.

8.4 When CPR would fail

Resuscitation should not be attempted in a situation where either:

- **Death is expected as an inevitable result of an underlying disease and there is no prospect of treatment that might modify its course.**

OR

- **A very sick patient is being actively treated with some hope of recovery and the clinical team is as certain as they can be that CPR would fail.**

If a DNACPR decision is made on clear clinical grounds that CPR would not be successful there must be a presumption in favour of informing the patient (or relevant others where a patient lacks capacity to understand) of the decision and explaining the reason for it unless it is clear that such a discussion would cause psychological or physical harm. Subject to appropriate respect for confidentiality, those close to the patient should also be informed and offered an explanation.

It is the responsibility of the medical and nursing team to ensure that the patient and family have the opportunity to be made aware of the severity of the patient's condition. See guidelines on discussing DNACPR decisions with patients and families (appendix 2).

Making a decision not to attempt CPR that has no realistic prospect of success does **not** require the consent of the patient or relevant others. The patient and relevant others have no right to insist on treatments that are clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.

Where the patient lacks capacity and has a welfare attorney or court-appointed deputy or guardian, this representative should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussion about the patient's care.

If the decision is not accepted by the patient or relevant others a second opinion should be offered.

8.5 Quality of life/ decisions based on benefits and burdens

Medical opinions should be based on immediate health needs, not on a professional's opinion on quality of life.

This is because opinions on quality of life made by health professionals are subjective and often at variance with the views of the patient and relevant others. Where CPR may be medically successful but would result in what is considered a poor quality or length of life, the patient's wishes about wanting or not wanting CPR to be attempted are of paramount importance. Patients should be informed in a sensitive manner of the facts and of the possible risks and adverse effects in order to make informed decisions about whether or not they would want CPR. Many people have unrealistic expectations about the likely success and potential benefits of CPR and lack detailed understanding of what is involved.

Relevant others can be given such information if the patient agrees. It is the professional's responsibility to ensure the patient is included in all discussions regarding CPR. If a patient lacks capacity or declines to be involved in discussions, then the clinical team must discuss CPR with their relevant others. Together they should decide the best option, taking into account the patient's previous wishes, if known. In the event of a dispute over the issue of best interests then a best interests declaration should be obtained from the Court of Protection. Relatives should never be placed in a position where they feel they are solely making a DNACPR decision unless they are the legally appointed proxy for the patient and acting within the scope of the power given to them by the patient (welfare attorney/person(s) with Lasting Power of Attorney).

It may be helpful to use the information leaflet produced by the Regional DNACPR Group. For more information refer to the Guidance from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing 3rd edition 2016: [Decisions relating to cardiopulmonary resuscitation.](#)

8.6 Presumption to resuscitate

Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (eg a person in the advanced stages of a terminal illness where death is imminent, unavoidable and CPR would not be successful) staff are expected to use their clinical judgement. A carefully considered decision not to start CPR would be reasonable and supported by their employer.

It is of great importance that teams caring for patients make CPR decisions so that resuscitation and paramedic teams are not placed in difficult circumstances. CPR and paramedic teams are asked to feedback any situations where they consider a DNACPR order should have been in place using their own organisation's incident reporting system.

9 MENTAL CAPACITY

- 9.1** Adults and young people over the age of 16 should be presumed to have capacity to make their own decisions unless there is evidence to the contrary. Patients are considered legally unable to make decisions for themselves if, at that time, they are unable to:
- Understand the information relevant to the decision
 - Retain that information
 - Use or weigh that information as part of the process of making the decisions
 - Communicate the decisions (whether by talking, using sign language, visual aids or by other means)
- 9.2** Where there is reason to doubt capacity it is important to establish whether patients do or do not have the mental capacity to make their own decisions relating to the specific CPR decision.
- 9.3** An assessment of capacity must relate to the specific decision the patient is being asked to make and their ability to comprehend their situation and the implications of their decision according to the principles of the Mental Capacity Act [2005].
- 9.4** Full guidance on establishing whether a patient has mental capacity can be found in the [Mental Capacity Act \[2005\] Code of Practice](#) and the Mental Capacity policy held by each organisation.

10 THE PROCESS OF MAKING A DNACPR DECISION

- 10.1** This process is summarised in a flow chart presented in appendix 3. Where the decision to be made relates to a young person age 16-17 this section must be read in conjunction with section 11 of this policy.
- 10.2** Where patients are admitted to an inpatient setting, transferred to a different team's care, transferred between settings or admitted to a community caseload their CPR status should be considered as soon as is reasonably possible. When no explicit decision has been made about CPR before a cardiopulmonary arrest and the express wishes of the patient are unknown, it should be presumed that staff would attempt to resuscitate the patient. Although this should be the general assumption it is unlikely to be considered reasonable to attempt to resuscitation on a patient who is clearly in the dying phase of a terminal illness.
- 10.3** Patients fall into one of the following categories:
- Patients for whom cardiopulmonary arrest is not anticipated
 - Patients for whom cardiopulmonary arrest seems likely and for whom CPR may have a successful outcome
 - Patients for whom cardiopulmonary arrest seems likely and for whom CPR is unlikely to be successful
 - Patients who have made an advance decision that they do not wish to receive CPR

10.4 To ease use of this policy in practice, the table below may be used to direct the reader to the relevant section.

Category of patient	Patients with mental capacity	Patients without mental capacity
Patients for whom cardio-pulmonary arrest is not anticipated	10.5 and 10.6	10.5
Patients for whom cardio-pulmonary arrest seems likely and for whom CPR may have a successful outcome	10.7	10.7
Patients for whom cardio-pulmonary arrest seems likely and for whom CPR is unlikely to be successful.	10.8	10.8
Patients who have made an advance decision that they do not wish to receive CPR.	10.6 & Appendix 4	Appendix 4

10.5 Patients For Whom Cardiopulmonary Arrest Is Not Anticipated

- If it is not possible to anticipate circumstances where cardio-pulmonary arrest might happen there is no clinical DNACPR decision to make
- A decision about the appropriateness of CPR can only be made if the situation(s) where CPR might be required can be anticipated for the particular patient (e.g. pneumonia on a background of advanced heart failure or far advanced cancer with poor performance status). If such a situation cannot be anticipated⁶ there is **no medical decision to make** and there is no need to burden patients with CPR decisions.
- Do not initiate discussion about CPR with the patient or relevant others
- The patient and relevant others should be informed that they can have a discussion or receive information about any aspect of their treatment. If the patient wishes, this may include information about CPR and its likely success in different circumstances. Use of the approved leaflet about CPR (see appendix 8) should be encouraged and the leaflet should be readily available for staff to use as required.
- Continue to communicate progress to the patient and relevant others if the patient agrees
- Review only when circumstances change
- In the event of an unexpected cardio-pulmonary arrest there should be a presumption that CPR would be carried out
- No DNACPR form should be completed

10.6 Advance statements and decisions

If a patient wishes to make an advance statement or decision that he/she would not wish to have CPR in the event of an unanticipated cardio-respiratory arrest, this should be explored in a sensitive and realistic manner by an experienced member of the clinical team. Staff must clarify that the patient fully understands the implications of such a request and the discussion must be fully documented in the medical notes. Patients who wish to refuse CPR in only certain future circumstances should be encouraged to make a formal Advance Decision as a DNACPR form would not be appropriate. Copies of advance statements and decisions should be kept in the medical records. For more information see appendix 4.

⁶ A useful question to inform your decision is “Would I be surprised if this patient died in the next year?”

10.7 Patients For Whom Cardio-Pulmonary Arrest Seems Likely And For Whom CPR May Have A Successful Outcome

If it is possible to anticipate circumstances where cardio-pulmonary arrest seems likely for a particular patient then it is possible to make a decision in advance, following discussion and consent from the patient.

Where CPR may be successful, consideration of the patient's wishes must be given priority.

If the patient has capacity to make this decision:

- Discuss the options with the patient, checking that the patient understands. Document and communicate their wishes accordingly
- Continue to communicate progress to the patient and relevant others if the patient agrees

Clinicians must not make a DNACPR decision for a patient with capacity based on a quality of life judgement unless the patient specifically requests that they do this.

If the patient does not have capacity to make this decision, clinicians must act in accordance with the Mental Capacity Act [2005] See relevant organisation Policy and Procedures for Implementation of the Mental Capacity Act (2005)

Firstly, it must be established whether the patient has made an **advance decision**⁷ stating that CPR must not be undertaken. If this is the case, CPR must not be attempted.

If the patient has not made an advance decision, it must be checked whether the patient has a welfare attorney with the expressly given authority to refuse or accept life sustaining treatment. If this is the case the welfare attorney must be consulted.

Where the patient has neither made an advance decision nor appointed a welfare attorney it must be established whether the patient has made an advance statement⁸ and any persons involved in the patient's care or interested in the person's welfare should be consulted to discuss the patient's known wishes. Those who should be consulted include people:

- The patient has previously stated that they wish to be consulted
- Involved in caring for the person
- Interested in the patient's welfare (eg family carers, other close relatives, parents or legal guardians of young people or an advocate already working with the person)

The language and communication needs of people who are consulted must be considered and interpreters offered where English is not the person's first language.

If the patient has no-one that it would be appropriate to consult other than paid staff, an Independent Mental Capacity Advocate (IMCA) must be appointed.

The purpose of consultation with these others is to inform the clinical team so that the senior hospital doctor or GP can make the most appropriate decision.

⁷ An **advance decision** is intended to be a binding refusal of certain kinds of treatment as specified by the person making the advance decision.

⁸ An **advance statement** is a statement of general beliefs and aspects of life which a person values. It may reflect individual aspirations and preferences and is sometimes called a 'personal values history'. The statement can be used to help health professionals and others such as family members to decide what sort of treatment the person would want if they were unable to communicate their wishes. However an advance statement would not bind healthcare professionals to a particular course of action if it conflicted with their professional judgment.

All consultations must be carefully documented in the patient's record.

Once the decision has been made, clinicians must:

- Clearly document the decision using the specified form (see appendix 6) if the decision is not to attempt CPR
- Communicate the decision to all members of the team
- Continue to communicate progress to any persons consulted

Further guidance is available from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing Decisions relating to cardiopulmonary resuscitation, 3rd 2016.

10.8 Patients For Whom Cardiopulmonary Arrest Seems Likely And For Whom CPR Is Unlikely To Be Successful

If the medical team is as certain as it can be that CPR would not realistically have a medically successful outcome, there should be a presumption in favour of informing the patient of the decision and explaining the reason for it (see section 5 of the guidance Decisions relating to cardiopulmonary resuscitation 3rd edition 2016). Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation.

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. It is poor practice to force discussions on patients who have stated clearly that they do not want them. Any such refusal should be documented clearly, together with a plan to ensure that optimal care of the patient is not compromised by that refusal. In such circumstances permission should be sought from the patient to discuss the issues with their relevant others.

Where the patient lacks capacity and has a welfare attorney or court-appointed deputy or guardian, this representative should be informed of the decision not to attempt CPR and the reasons for it as part of the on-going discussion about the patient's care.

If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

All consultations must be carefully documented in the patient's records.

Once the decision has been made, clinicians must:

- Clearly document the decision, using the specified form (see appendix 6) if the decision is not to attempt CPR
- Communicate the decision to all members of the team
- Continue to communicate progress to any persons consulted

11 YOUNG PEOPLE AGED 16 AND 17 YEARS – SPECIAL CONSIDERATIONS

11.1 Some special considerations apply where patients are aged 16 or 17 years.

Current practice relating to young persons

NICE guidance (End of life care for infants, children and young people with life-limiting conditions: planning and management (NG61), 2016) recommends that:

- An Advance Care Plan should be developed at an appropriate time for the current and future care of each (child) or young person with a life-limiting condition. This should include preferred place of care and place of death, organ and tissue

donation, management of life-threatening events, including plans for resuscitation or life support

- All children and young people with life-limiting conditions should have an Advance Care Plan in their medical record and that this should not be confused with a do not attempt resuscitation order.
- Attempt resuscitation for (children) and young people with life-limiting conditions, unless there is a 'do not attempt resuscitation' order in place.
- Be aware that any existing resuscitation plan for a (child) or young person may need to be changed in some circumstances, for example if they are undergoing general anaesthesia.

[Together for Short Lives \(A Core Care Pathway for Children with Life-limiting and Life-threatening Conditions, third edition 2013\)](#) also recommends that every young person with a life limiting condition must be helped, with their family, to decide on an end of life or palliative care plan.

In the areas covered by the signatories' organisations it is current practice for young people known to the children's palliative care services to have an individualised palliative care plan. This may include decisions about a limitation of treatment agreement (LOTA). This palliative care plan will be reviewed at minimum every six months in the community (or more frequently if there is a major change) by the lead paediatrician, palliative care practitioner and family. The plan is held by the patient/family and distributed to all agencies involved with that young person including the GP. The plan is usually formulated and distributed by the child's palliative care practitioner or paediatrician. A LOTAs must be reviewed at minimum every two weeks when a hospital inpatient and six monthly in the community.

The palliative care plan, though not a legal document, includes the cardiopulmonary resuscitation status of the young person. A LOTAs is accepted as the equivalent of a DNACPR and the wishes within this should be followed on presentation of the original signed copy which must be in date.

If a LOTAs states that the young person is not for CPR this plan should NOT normally be replaced by the DNACPR form attached to this policy until that young person transitions into adult services.

11.2 Who should or could initiate discussion, and when?

It can be appropriate for professionals looking after young people with life limiting or life threatening conditions to initiate discussion about end of life planning well before the young person is terminally ill. It may also be appropriate to begin discussions if a young person has an acute illness or repeated illness as a result of which it becomes clearer to professionals and/or the parents that the young person is potentially moving into a terminal phase of their illness, or that they are at an increased risk of a more sudden life threatening illness/event. Usually the most appropriate professional to initiate this discussion is the named paediatrician or palliative care practitioner.

Professionals may initiate discussions with the patient but consideration should be given to the sensitive timing of this. Further support for the family and young person may be necessary. Decision making should not be forced on a young person or family. If a professional initiates a discussion about DNACPR and the young person/family indicate they do not wish to continue, their wishes should be respected and the details recorded in the medical record.

Discussions may be initiated by the young person or family at any time.

11.3 Who can make decisions?

The Department of Health (2009) state that:

By virtue of section 8 of the Family Law Reform Act 1969, young people aged 16 and 17 are presumed to be capable of consenting to their own medical treatment. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

To establish whether a young person aged 16 or 17 has the capacity to consent to a proposed intervention, the same criteria should be used as for adults. If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over (Department of Health 2009).

Where a young person lacks capacity to decide, a person with parental responsibility may express their view on behalf of the patient regarding a DNACPR decision where they consider that to be in the young person's best interests.

If a 16 or 17 year old is capable of making an informed decision then it is not legally necessary to obtain additional consent from a person with parental responsibility. It is, however, good practice to involve the young person's family in the decision-making process unless the young person specifically wishes to exclude them.

If a young person (with capacity to do so) decides that he/she does not wish to be resuscitated and that the family should not be involved with or informed about the decision, this must be urgently referred to the head of service as specific legal advice may need to be sought. This consent should be sought for all young people over the age of 16.

11.4 What is, and who has, parental responsibility?

Parental responsibility means the rights and responsibilities that parents have in law for children aged under 18 (in England), including the right to consent or withhold consent for medical treatment. Parental responsibility is relinquished on a young person's eighteenth birthday.

The Children Act 1989 sets out persons who may have parental responsibility. These include:

- The child's mother
- The child's father if he was married to the mother at the time of birth
- Unmarried fathers, who can acquire parental responsibility in several different ways:
 - For children born before 1 December 2003, unmarried fathers will have parental responsibility if they:
 - Marry the mother of their child or obtain a parental responsibility order from the court
 - Register a parental responsibility agreement with the court or by an application to court
 - For children born after 1 December 2003, unmarried fathers will have parental responsibility if they:
 - Register the child's birth jointly with the mother at the time of birth
 - Re-register the birth if they are the natural father
 - Marry the mother of their child or obtain a parental responsibility order from the court
 - Register with the court for parental responsibility
- The child's legally appointed guardian
- A person in whose favour the court has made a residence order concerning the child
- A local authority designated in a care order in respect of the child
- A local authority or other authorised person who holds an emergency protection order in respect of the child

It should be noted that:

- If a child is in local authority care parents can share parent responsibility with the local authority – this is lost if the child is adopted.
- Parental responsibility can also be restricted by a court order
- Foster parents do not automatically have parental responsibility

11.5 Children in local authority care

Where a child is in the care of the local authority the child's social worker must be involved in all of the discussions as well as parents, as the local authority shares parental responsibility with the parents.

11.6 Decision-making with young people may be a matter of negotiation between the child, those with parental responsibility and clinicians. Inevitably there will be times when young people and those with parental responsibility for them do not agree about whether a DNACPR decision should be made.

If a young person is deemed to have the capacity to make a DNACPR decision (or believes he/she has capacity to make a decision?) and there is disagreement between the patient and those with parental responsibility despite attempts to reach agreement, legal advice should be sought.

11.7 What happens when medical staff and a young person or persons with parental responsibility disagree about a DNACPR decision?

Where medical staff are strongly of the opinion that cardiopulmonary resuscitation should not be attempted but the young person or people with parental responsibility disagree, or vice versa, a legal opinion should be sought.

11.8 Safeguarding issues

Where there is doubt about whether a person with parental responsibility is acting in the interest of the young person, then local safeguarding procedures must be instigated.

11.9 Education Establishments

Potentially a young person may wish to continue at school with an agreed DNACPR decision in place. This can potentially cause anxieties for both the family and staff supporting that young person. Advice can be sought from a palliative care practitioner in dealing with those anxieties and what measures can be put in place to support the child and family during this period.

11.10 Interface with the child death overview process

All deaths of people under 18 years of age must be discussed and reviewed by the child death overview panel of the Bradford Safeguarding Children Board in accordance with the statutory guidance in Working Together to Safeguard Children 2010. It is important that following a death the Child Death Overview Panel (CDOP) Manager is informed of any DNACPR agreement or care plan when the death is reported.

12 REVIEWING AND RESCINDING DNACPR DECISIONS

12.1 Whenever a DNACPR form is signed, a decision must be made as to whether or not the DNACPR status will need to be reviewed. The following criteria should be applied in deciding this:

- (1) Where this is **no** realistic prospect of the patient's condition improving, there is **no** obligation to set a review date. Section 2 (ii) of the DNACPR form should be completed, with supporting rationale documented in the medical notes.
- (2) If the patient has expressed a wish not to receive CPR there is no obligation to set a review date and the decision may remain valid until end of life.
- (3) If it is thought **possible** that a patient's condition may **improve**, the DNACPR status must be reviewed as follows:

ANHSFT, BDCFT or BTHFT Inpatients

- At least fortnightly at the consultant ward round or MDT meeting
- On each admission to hospital
- Prior to discharge or transfer to another care setting

Community Patients

- By a specified date set by their General Practitioner

Section 2 (i) of the DNACPR form should be completed with an appropriate date.

12.2 Rescinding a DNACPR decision

A DNACPR form may only be rescinded by an appropriate senior doctor or health professional, as defined in Para 5.5 and 5.6 above.

Section 2 (i) of the form should be completed. In addition, a diagonal line should be clearly drawn across the whole of the form.

- In exceptional circumstances, such as if the senior doctor is attending another medical emergency or is not on site, the form can be rescinded and signed by a more junior doctor or appropriately trained health care professional **AFTER** discussion with an appropriate senior doctor.
- Details of the discussion between the medical staff and/or nursing staff and the patient regarding the rescindment should be fully documented in the medical notes.
- Countersignature by a consultant, speciality doctor or ST3 is required as soon as possible and definitely within 24 hours.

IMPORTANT – IN ALL SETTINGS

If there are significant improvements in a patient's condition **at any time**, the DNACPR status should be reviewed and discussed with the patient and relevant others **whether or not** a review date has been set.

It is the responsibility of the medical and nursing staff to bring any significant improvement to the attention of the senior doctor or nurse in charge.

Whenever a DNACPR status is reviewed, the clinician should discuss with the patient as per guidance in Section 8. It is important to remember that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition.

13 RECORD KEEPING AND COMMUNICATION

13.1 All DNACPR decisions must be documented using the agreed form (see appendix 6). The circumstances surrounding the decision must be clearly stated together with who was involved in the decision making process and should be evidenced by full and clear documentation in the

patient's record. For the regional DNACPR form to be valid it must be the original and may be printed with either a **black** or **red** border.

13.2 Each organisation has its own arrangements for the storage of the DNACPR form and the communication of information both internally and externally. These agreed procedures are attached as appendix 5 and appendix 8 (AGHFT)

13.3 The following principles apply:

- The person who makes a CPR decision is ultimately responsible for ensuring that the decision is communicated effectively to other relevant health professionals in both primary and secondary care. The task of disseminating information about the decision to others providing care to the patient may be delegated to another member of the healthcare team but it should be clear who has responsibility for ensuring that this task is undertaken.
- The senior nurse is responsible for ensuring that every CPR decision is recorded in the nursing records (where medical and nursing records are held separately) and that all those nursing the patient are aware of the decision.
- Whenever a patient is transferred within or between establishments or discharged home it is imperative that CPR decisions are communicated between all who need to know. This includes the ambulance crew⁹ and the receiving organisation/team (Appendix 5)

14 DIFFICULTIES IN DECIDING A DNACPR ORDER

14.1 It is important to be sensitive to the cultural and individual circumstances which have influence on these decisions.

14.2 Patients should be made aware of arrangements for emotional and spiritual support including chaplaincy arrangements where these exist. They should be supported if they wish to discuss their decisions or wishes with someone who shares their faith or beliefs.

14.3 Some patients will wish to receive CPR despite marked disability from an advanced and irreversible condition. Where CPR might be successful, offering CPR to these patients is our acknowledgement of their desire to continue treatment. An unsuccessful CPR attempt may make the bereavement of relevant others less complicated since all possible treatments were carried out.

The original Tracey versus Cambridge University Hospital NHS Foundation Trust & Others judgement commented on this:

“Doctors cannot be required to give treatment contrary to their clinical judgement, but should be willing to consider and discuss patients’ wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where attempted CPR has a reasonable chance of successfully restarting the heart and breathing for a sustained period, and patients have decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. In the unusual circumstance in which the doctor responsible for a patient’s care feels unable to agree to the patient’s expressed wishes for attempted CPR, or where there is a lack of agreement within the healthcare team, seeking a second opinion is recommended so that patients may be given an opportunity to review their decision in the light of further advice.”

⁹ Clinical guidelines issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) advise ambulance staff that they should always initiate CPR unless:

- There is a formal DNACPR decision, or valid and applicable advance decision made by the patient, which has been seen by the ambulance crew, and the circumstances in which CPR may be attempted are consistent with the wording of the DNACPR decision or advance decision; or
- The patient is known to be terminally ill and is being transferred to a palliative or terminal care facility (unless specific instructions have been received that CPR should be attempted).

14.4 Some will wish to refuse CPR despite an apparently reasonable quality of life. Withholding CPR from these patients is our acknowledgement of their wish and can make the bereavement of relevant others less complicated since they feel the patient had their wishes respected.

15 REQUESTS FOR CPR IN SITUATIONS WHERE IT WILL NOT BE SUCCESSFUL AND WHEN CONSENSUS IS DIFFICULT TO ACHIEVE

Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. If the healthcare team believes that CPR will not be successful this should be explained to the patient in a sensitive way. These discussions may be difficult and should be carried out by a senior doctor or nurse. If the patient does not accept the decision and requests a second opinion, this should be arranged whenever possible. A second opinion should be offered when:

- The patient and/or those close to them do not accept a DNACPR decision despite a careful explanation
- There is disagreement amongst the team about whether CPR could be successful

15.2 Staff or relevant others with continuing concerns should approach the consultant, GP or senior nurse for discussion.

15.3 Staff who continue to have concerns should approach their managers as per their organisation's clinical governance procedures.

15.4 The courts may have to be approached for the final say. This is usually a last resort, although courts can be helpful in deciding complex cases.

16 THE ROLE OF THE FAMILY AND RELEVANT OTHERS

- 16.1** Throughout this document the term “relevant others” is used to describe patients’ spouses, partners, relatives, parents or legal guardians of young people, carers (who are not acting in a paid, professional capacity), representatives, advocates, people with parental responsibility, people with lasting power of attorney, independent mental capacity advocates (IMCAs) and court appointed deputies.
- 16.2** If a patient has capacity, his or her agreement must be sought before discussing CPR issues with the relevant others. Where a patient with capacity refuses to allow such information to be disclosed to relevant others this refusal must be respected.
- 16.3** Family often see themselves as natural decision makers in this situation and may be surprised and/or distressed if they are not allowed to “protect” the patient from such sensitive discussions. Sensitive exploration of these issues should be undertaken by experienced medical and/or nursing staff.
- 16.4** It is generally good practice to involve those closest to the patient in discussions about CPR decisions and patients should be encouraged to let staff know who they would like to be involved. Patients should also be asked who they would like to be involved in such discussions if and when they are no longer competent to do so themselves.
- 16.5** Relatives should never be given the impression that their wishes override those of the patient. They can give information about the patient’s wishes but should not be burdened with the decision unless their status as proxy for the patient has been legally established.
- 16.6** According to the Mental Capacity Act [2005] only a formally appointed proxy with lasting power of attorney (welfare attorney) is able to make decisions for a patient who lacks capacity.
- 16.7** Relevant others should never be burdened with feeling they are making a sole decision about CPR. Where CPR might be successful, the role of relevant others is to assist the patient in decision-making or to state what they understand the patient’s wishes to be.
- 16.8** If an adult lacks capacity and has no family, significant other or legal proxy to speak on their behalf, the Mental Capacity Act 2005 requires an independent mental capacity advocate (IMCA) to be consulted regarding all serious medical treatment decisions. In every case where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a DNACPR decision is being considered on the balance of benefits and burdens, an IMCA must be involved. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician in charge of the patient’s care as part of the determination of the patient’s best interests.
- 16.9** If a DNACPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and recorded in the health record. The decision should be discussed with an IMCA at the first available opportunity.

17 RELATED TRAINING

Basic life support training includes discussion about the DNACPR policy and expectations.

Basic Life Support training is mandatory for all staff with direct patient/ client contact, including those who manage patients with anaphylaxis (e.g. following immunisation) or to support staff managing patients requiring defibrillation (AED). A minimum requirement would be an annual update. Each organisation will outline their expectations in relation to other staff training within their respective training needs analysis.

18 DNACPR DECISIONS IN SITUATIONS RESULTING FROM READILY REVERSIBLE CAUSES

- 18.1** Uncommonly, some patients for whom a DNACPR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.
- 18.2** In addition to readily reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiopulmonary arrest.
- 18.3** This should be discussed with the patient, or their representative if they lack capacity, as part of the consent process. Some patients may wish a DNACPR decision to remain valid despite the increased risk of a cardio respiratory arrest and the presence of potentially reversible causes; others will request that the DNACPR decision is suspended temporarily.

19 MONITORING COMPLIANCE AND EVALUATION

Each organisation will have mechanisms in place to monitor compliance with this policy, these should be in line with NHSLA and CQC. This may be through audit or data gathering. Where failings are identified, action plans should be developed and changes implemented.

In those organisations providing clinical care, where there is a responsibility to complete DNACPR forms, the compliance with this policy should be measured by regular random sample audits of completed DNACPR forms. The audits should ensure forms are completed in accordance with the guidelines on page 2 of the DNACPR form. As a minimum audits should check:

- Are the patients details legible and in black ink
- Is the reason for DNACPR recorded
- If option D is chosen, has this been discussed with a carer/family member
- Is a review date recorded
- Where a review has taken place, is there a 'next review date'

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21 Key Related Documents

This policy should be read alongside each organisation’s key documents relating to:

- Consent to examination or treatment

- The Mental Capacity Act [2005]
- Safeguarding adults
- Equality and diversity
- Communication support for patients whose first language is not English
- Safeguarding children
- Resuscitation Policy

Appendix 1

THE DEVELOPMENT OF THIS POLICY

This policy and associated documents were developed by a multi-agency team representative of all NHS organisations operating in Bradford:

- Airedale NHS Foundation Trust
- NHS Bradford and Airedale
- Bradford District Care Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

and our out of hours general practice service provider, Local Care Direct.

	List Groups and or Individuals Consulted
Those listed opposite are members of the Bradford and Airedale Palliative Care Managed Clinical Network who have been consulted in the review of version 10 of this policy and comments/actions incorporated as required.	BAWC Local DNACPR Working Group
	Dr Ian Fenwick – End of Life Lead NHSBAWC
	Dr Andrew Daley – Consultant Palliative Medicine (BTHFT)
	Dr Helen Livingstone – Consultant Palliative Medicine (AGH)
	Catriona McKeating, Consultant Paediatrician (BTHFT)
	Danielle Lewis, Paediatric Palliative Care Nurse (Community, BTHFT)

Appendix 2

GUIDELINES ON DISCUSSING DNACPR ORDERS WITH PATIENTS AND FAMILIES

DNACPR discussions with seriously ill patients should always take place in the context of the broader goals of care, using a step-wise approach. The most appropriate senior clinician or nurse should conduct the discussion. Consider using an information leaflet.

Establish the setting

Check whether family members or others should be present. Ensure comfort and privacy; sit down next to the patient. Introduce the subject with a phrase such as:

“I’d like to talk with you about possible health care decisions in the future”.

What does the patient understand?

An informed decision about DNACPR status is only possible if the patient has a clear understanding of their illness and prognosis. Ask an open-ended question to elicit patient understanding about their current health situation. It is important to get the patient talking--if the doctor is doing all the talking, it is unlikely that the rest of the conversation will go well. Consider starting with phrases such as:

“What do you understand about you current health situation?”

or

“What have you been told about your condition?”

If the patient does not know/appreciate their current status this is time to review that information.

What does the patient expect?

Next, ask the patient to consider the future. Examples of ways to start this discussion are:

“What do you expect in the future?”

or

“What goals do you have for the time you have left—what is important to you?”

This step allows you to listen while the patient describes a real or imagined future. Most patients with advanced, life limited disease use this opening to voice their thoughts about dying—typically mentioning comfort, family, and home, as their goals of care. If there is a sharp discontinuity between what you expect and what the patient expects, this is the time to clarify.

Listen carefully to the patient’s responses; most patients have thought a lot about dying, they only need permission to talk about what they have been thinking. Setting up the conversation in this way permits the physician to respond with clarifying and confirming comments such as:

“So what you’re saying is, you want to be as comfortable as possible when the time comes”

or

“What you’ve said is, you want us to do everything we can to fight, but when the time comes, you want to die peacefully.”

Whenever possible, ask patients to explain the values that underlie their decisions:

“Can you explain why you feel that way?”

Discuss a DNACPR order

Use language that the patient will understand, give information in small pieces. Don't introduce CPR in mechanistic terms (e.g. “starting the heart” or “putting on a breathing machine”). Never say, “Do you want us to do everything?” “Everything” is euphemistic and easily misinterpreted. Using the word “die” helps to clarify that CPR is a treatment that tries to reverse death. To a layman, when the heart and/or lungs stop, the patient dies.

If the patient and doctor mutually recognize that death is approaching and the goals of care are comfort, then CPR is not an appropriate medical intervention and a clear recommendation against CPR should be made. You can say:

“We have agreed that the goals of care are to keep you comfortable and get (or keep) you wherever you would like your care to be. With this in mind, I do not recommend the use of CPR - that means pressing repeatedly and hard on your chest and breathing in to your mouth to keep you alive. If you agree with this, I will write an order in your medical and nursing records that if you die, no attempt to resuscitate you will be made, is this ok with you?”

If the clinical situation is more ambiguous in terms of prognosis and goals of care, and you have no clear recommendation, the issue of DNACPR can be raised by asking:

“If you should die in spite of all of our efforts, do you want us to try and get your heart restarted? This would mean forcefully pushing down on your chest, artificial ventilation and possibly an electric shock to the heart

or

“How do you want things to be when you die?”

Offer the booklet ‘What happens if My Heart Stops’ to patients and/or families to explain further.

Respond to emotions

Strong emotions are common when discussing death. Typically the emotional response is brief. The most profound initial response a physician can make may be silence, providing a reassuring touch, and offering tissues.

Establish a plan

Clarify the orders and plans that will accomplish the overall goals you have discussed, not just the DNACPR order. A DNACPR order does not address any aspect of care other than preventing the use of CPR. It is unwise and poor practice to use DNACPR status as a proxy for other life-sustaining therapies. Consider using words:

“We will continue maximal medical therapy to meet your goals. However, if you die in spite of everything, we won't use CPR to bring you back.”

or

“It sounds like we should move to a plan that maximizes your comfort. Therefore, in addition to a DNACPR order, I'd like to ask my palliative care colleagues to give you some information.”

Persistent requests for CPR - understanding why?

If you have followed those steps, what do you do if the patient or family/surrogate continues to want CPR and you think it is not in the patient's best interest? The seemingly unreasonable request for CPR typically stems from one of several themes:

Inaccurate information about CPR.

The general public has an inflated perception of CPR success (1). While most people believe that CPR works 60-85% of the time, in fact the actual survival to hospital discharge is more like 10-15% for all patients and less than 5% for the elderly and those with serious illnesses. This is a time to review/clarify the indications, contraindications, potential outcomes and morbidity of CPR. Start a discussion by asking,

“What do you know about CPR?”

Hopes, fears and guilt.

Be aware that guilt (I haven't lived nearby to care for my dying mother) and fear (I am afraid to make a decision that could lead to my wife's' death) are common motivating emotions for a persistent CPR request. Some patients or families need to be given an explicit recommendation or permission from the physician, to stop all efforts to prolong life, to be told that death is coming and that they no longer have to continue "fighting". Whenever possible, try to identify the underlying emotions and offer empathic comments that open the door to further conversation:

"This decision seems very hard for you."

"I want to give you the best medical care possible; I know you still want CPR, can you tell me more about your decision?"

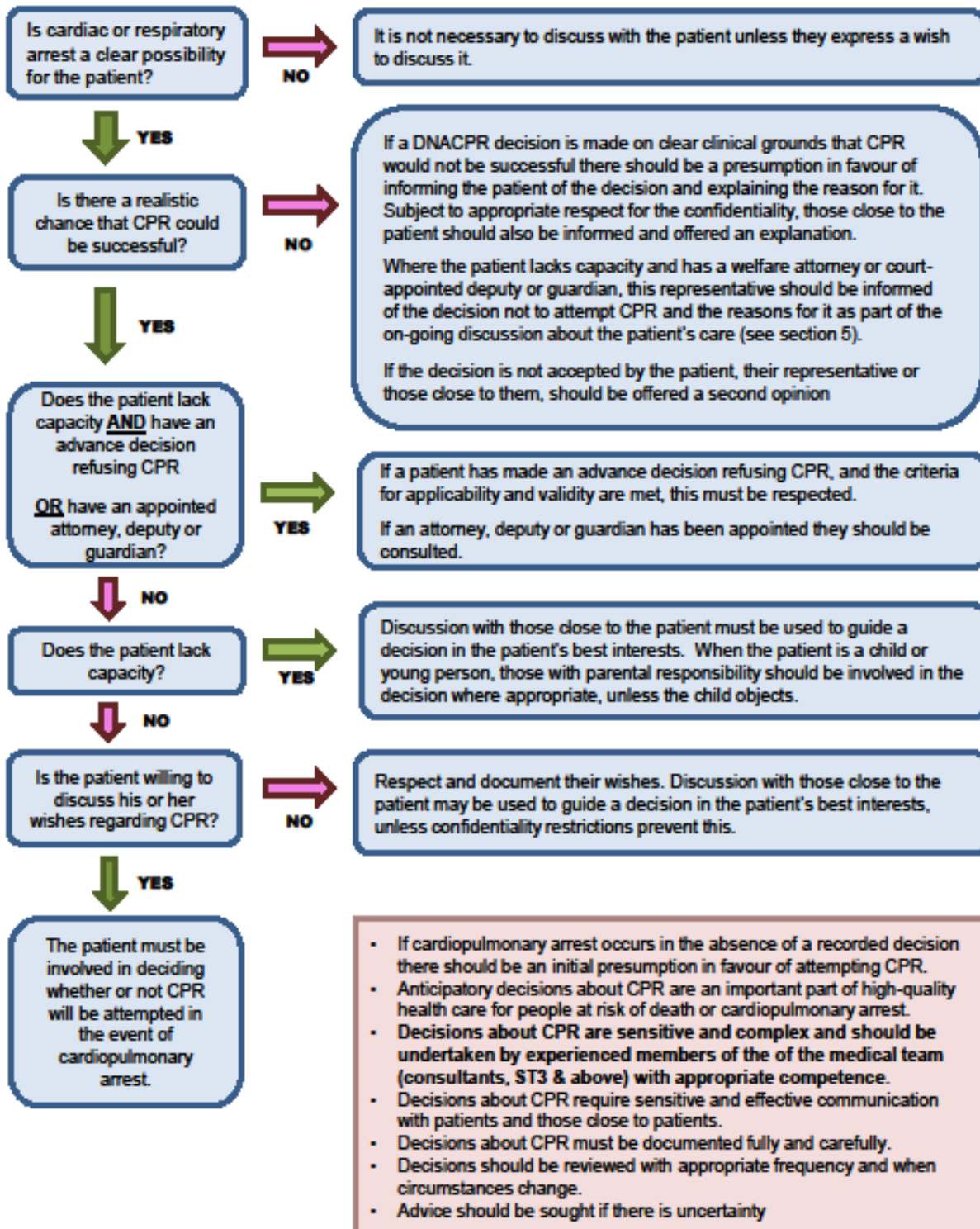
Agreeing to a DNACPR order for many patients is equivalent to their "choosing" to die. Acceptance of impending death occurs over a vastly different time course for different patients/families; for some, it never occurs. Some patients see CPR as a "last chance" for continued life. Probe with open-ended questions:

“What do you expect to happen--What do you think would be done differently, after the resuscitation, that wasn't being done before?”

Most patients usually describe hope for a new treatment. Use the opportunity to respond by describing that you are doing everything in your power to prolong their life before a cardiopulmonary arrest--you wouldn't be "saving something" to do after they had died. If patients are not ready for a DNACPR order, don't let it distract you from other important end-of life care needs; emphasize the goals that you are trying to achieve; save a repeat discussion for a future time; good care, relationship building and time will help resolve most conflicts.

CPR Decision-Making Framework

Decisions relating to CPR October 2014



Appendix 4

ADVANCE STATEMENTS, ADVANCE DIRECTIVES AND LIVING WILLS

Advance Statements

This is a statement of a patient's views and wishes indicating preferences and what forms of medical treatment a patient would or would not want to receive should they be unable to communicate their wishes at a later date. It does not need to be a written statement but if a patient has strong views about what treatment they would or would not want in certain future circumstances they should be encouraged to discuss this with medical or nursing staff so that it can be documented for future reference. An advance statement can also be used to indicate a particular person that the patient would like to be consulted regarding their wishes if the patient becomes unable to take part in decision-making. Patients should be made aware that appointing a legal proxy is preferable as they would have the legal power to make decisions for the patient under the Mental Capacity Act 2005 (Lasting Power of Attorney).

Where an advance statement relates to the patient's wish to not have cardio-pulmonary resuscitation in the event of a future unexpected cardiac and/or respiratory arrest, a DNACPR form may not be appropriate and a patient should be encouraged to formulate a more formal advance decision. In the event of an unexpected arrest, a clinical judgement will need to be made regarding whether the circumstances of the arrest are covered by the advance statement.

Advance Decision to Refuse Treatment (ADRT)

These are a type of advance statement in the form of a more formal written document detailing the patient's wishes regarding future treatment for a situation where they had become unable to express their wishes. Advance decisions are covered by the Mental Capacity Act 2005. Many organisations provide information about completing an advance decision and the patient can also get advice and guidance from their own lawyer. The Act confirms that an advance decision refusing CPR will be valid, and therefore legally binding on the healthcare team, if:

- the patient 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 patient's life is at risk
- the advance decision has not been withdrawn
- the patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- the patient has not done anything clearly inconsistent with its terms
- the circumstances that have arisen match those envisaged in the advance decision.

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

An advance statement/decision of any kind may not be used by a patient to do the following;

- (1) request anything that is illegal such as euthanasia or for help to commit suicide
- (2) demand any treatment that is contrary to the clinical judgment of the healthcare team
- (3) refuse *the offer* of food and drink by mouth.

Where there is doubt or disagreement regarding the patient's competence, prognosis or best interests the validity of the advance decision with regard to withholding or administering treatment according to an advance decision, legal advice should be sought.

Further guidance can be obtained from:

The Mental Capacity Act [2005] Code of Practice <http://www.publicguardian.gov.uk/mca/code-of-practice.htm>

British Medical Association www.bma.org.uk

General Medical Council www.gmc-uk.org

Patients Association www.patients-association.com

Terrance Higgins Trust www.tht.org.uk

Alzheimer's Society <https://www.alzheimers.org.uk>

Motor Neurone Disease Association www.mndassociation.org

STORAGE OF THE DNACPR FORM, INTERNAL AND INTERAGENCY COMMUNICATION

Process to communicate and implement the Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form across Bradford and Airedale

Introduction

The flow of information and correct documentation is crucial to the success of this process. Where an individual may move care settings, and the DNACPR decision has been reviewed and still applies the following core principles are applicable.

Core principles

- For the regional DNACPR form to be valid it must be the original and may be printed with either a black or red border
- Whilst in Hospital, the DNACPR form will remain in the case notes, in accordance with local hospital policy.
- As patients move between care settings, the DNACPR form moves with the patient in a clearly marked envelope.
- In all other care settings the DNACPR form should be located in the front of the care record / nursing record.
- If no nursing record exists in the home, the patient/family/carer will determine the best place to store it, and communicate this to the health care professionals.
- Ambulance control is informed that a DNACPR form exists at the time of booking a patient transport services (PTS) ambulance.
- Ambulance crew (the registration clerk) will routinely request the DNACPR status at the point of booking patient transport services, and communicate this to the crew.
- The discharging organisation will give the original DNACPR form to the ambulance crew in a clearly marked envelope and inform the patient's GP and out of hours service as appropriate of the patients DNACPR status.
- If an ambulance is called in an emergency that is not life threatening but requires transfer to A&E, i.e. from a community hospital or home. The crew will be handed the care record with the DNACPR form at the front of it, **or** a clearly marked envelope with the DNACPR form in. On arrival at the care setting the crew will hand formally hand-over the DNACPR form to the member of staff responsible for the patient.

To cancel a DNACPR order, the original form must be marked with two thick diagonal lines and the word **CANCELLED** should be written across the form with the date and the signature of the clinician cancelling the form.

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over (v13)

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		Relationship
Address		
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR decision: Select as appropriate from A - D

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

A. CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision. *(Guidance overleaf)*

B. CPR is against the wishes of the patient as recorded in a valid advance decision *(Guidance overleaf)*
 The right to refuse CPR in an Advance Decision only applies from the age of 18.

C. The outcome of CPR would *not* be of overall benefit to the patient **and**: *(Guidance overleaf)*
 i) They lack the capacity to make the decision or
 ii) They have declined to discuss the decision
This represents a best interests decision and must be discussed with relevant others

This **has** been discussed with(name) ON..... (date/time) Relationship to patient:.....

D. CPR would be of *no clinical benefit* because of the following medical conditions: *(Guidance overleaf)*

In these situations when CPR is not expected to be successful,
 it is good practice to explain to the patient and/or relevant others why CPR will not be attempted.

This **has** been discussed with the patient Date:...../...../..... Time:.....

This **has not** been discussed with the patient Specify Reason:

This **has** been discussed with(name) ON.....(date/time) Relationship to patient:.....

Section 2 Review of DNACPR decision: Select as appropriate from i OR ii

i) DNACPR decision is to be reviewed by: *(specify date)*

Review Date	Full Name and Designation	Signature	DNACPR still applies	Next Review Date
			<input type="checkbox"/> <i>(tick)</i>	
			<input type="checkbox"/> <i>(tick)</i>	
			<input type="checkbox"/> <i>(tick)</i>	

ii) DNACPR decision is to remain valid until end of life *(tick)*

Section 3 Healthcare professionals completing DNACPR form *(Guidance overleaf)*

Date: Time:	<i>(Countersignature if required)</i> Date: Time:
Signature:	Signature:
Print name:	Print name:
Designation & Organisation	Designation & Organisation
GMC / NMC No:	GMC / NMC No:

These guidelines are based on an agreement within the Yorkshire and Humber region.

This form can be red or black-bordered.

For more details refer to your local policy relating to DNACPR.

This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (Please write legibly and with black ink)

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

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

Option C

1. The term "overall benefit" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "best interests" as defined by the Mental Capacity Act, 2005.
2. Whenever possible, this situation **must** be discussed with relevant others before completing the form. Record details of your discussion in the patient's notes.
3. The term "relevant others" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) <http://www.dh.gov.uk>

Option D

Record underlying condition/s (e.g. poor Left Ventricular Function, End stage obstructive airway disease, disseminated malignancy) and complete necessary discussions with patient and/or relevant others as soon as possible

Section 2 Review – In accordance with your Local Policy

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (e.g. hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

Cancellation of DNACPR: When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing CANCELLED in large capitals and adding your signature and date. It should then be filed in the patient's notes.

Section 3 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

Countersignature: If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Any supplementary information (e.g. family informed by nursing staff at later stage) should be signed and dated by the entry.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare team completing the form to ensure that the DNACPR status is communicated to all who need to know.

For patients being transferred between different care settings, it is essential that:

1. Where patients are being transferred to community (e.g. home or care home): the DNACPR status and an explanation of the role of the form in an emergency should be communicated to patient (if appropriate) and 'relevant others'.
2. Send the **original form** with the patient. A photocopy or carbon copy version should be retained in the patient's notes for audit, marked with the words 'COPY' in large capitals, signed and dated.
3. For discharges to community settings: communicate to the GP, Out of Hours service and any other relevant services as appropriate.

v13 January 2014
Regional Review Date: January 2017
Regional Lead Contact: Palliative Medicine Consultant
Calderdale & Huddersfield NHS Foundation Trust, West Yorkshire

Appendix 7 Equality and Diversity assessment (2014)

It has potential impact on:

- Age – there is evidence that suggests discussing DNACPR can have significant psychological and/or physical harm across age ranges on both older and younger patients.
- Disability
 - Concern from people with communication impairments and other impairments about judgements being made about the person's "quality of life", based on non-disabled norms and perceptions that some disabled people are a "burden".
 - There are instances where laws to protect people with learning disabilities are being ignored by the NHS in England.
 - People with mental health needs are recognised as being "at risk" (Safeguarding Adults)
- Race and ethnicity – there is no data available on the breakdown by ethnicity on resuscitation and non-resuscitation. Little evidence that the language/ communication and cultural needs of BME patients are being met during the implementation of the policy. The policy has been changed to make explicit the need to provide appropriate, professional interpretation when discussing options. There is also evidence that some ethnic groups have different perceptions, behaviour and choice when deciding on resuscitation.¹ Also "Legal implications of deciding to withhold resuscitation can be particularly difficult when the cultural background of the doctor and patient differ".

It is has been found not to have impact on:

- Gender – no evidence to suggest a difference in rates of resuscitation between women and men.
- Gender reassignment – no evidence of impact
- Marriage and civil partnership – no evidence of impact
- Maternity/pregnancy– no evidence of impact
- Religion and belief – no evidence of impact although some religious belief will affect the decision to attempt or not attempt resuscitation
- Sexual orientation