DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) POLICY

(FOR NORTH AND NORTH-EAST LINCOLNSHIRE)
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12 Key Points of Resuscitation Decisions

This section is not intended to be read in isolation but as an aide-memoire. Given the very serious implications of Cardio Pulmonary Resuscitation (CPR) decisions readers are urged to make time to read the whole policy and explore the guidelines and literature cited. The sections dealing with key points are in bold type for ease of navigation when using the document as a reference.

1. CPR decisions must be based on an individual assessment of each patient’s case. Section 5-7.

2. As part of advance care planning for each patient at risk of cardiorespiratory arrest, decisions about CPR must be considered as early as possible. Section 5.

3. There is no need to initiate discussions about CPR if the patient is not likely to suffer a cardiorespiratory arrest. Section 5.

4. Good communication and information sharing are essential to high quality care and decisions relating to CPR. Sections 8-10, 17.3, 19 and 21.

5. If no explicit CPR decision has been made in advance, or the person responding to a patient in cardiorespiratory arrest is not aware of a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form, there should be an initial presumption in favour of CPR. Section 5.

6. If the GP or Senior doctor/senior clinician in charge of the patient’s care believes CPR will not restart the heart and maintain breathing, it should not be attempted. Section 7.1.

7. If the expected benefits of CPR are outweighed by the burdens, it is essential to involve the patient in any decision. If the patient lacks capacity their Relevant Others must be involved in discussions to gain insight into the patient’s wishes, feelings, beliefs and values. The statutory framework for this process is set out in the Mental Capacity Act 2005 Code of Practice (1). Sections 9 and 10. (Please see section 25 definitions for “Relevant Others”).

7b. If the patient does not want to discuss the issue their relevant other could be involved in the discussion with the patients consent. Section 8.

8. If a clinical team is clear that CPR would be futile, it is essential to communicate that decision to the patient or their Relevant Others, save in exceptional circumstances (i.e. where communicating the decision would cause demonstrable physical or psychological harm to the patient.) or where the patient declines to discuss the decision and does not give permission for relevant others to be involved. Section 8.

9. If a patient with mental capacity refuses CPR, or a patient lacking mental capacity has a valid and applicable advanced decision refusing CPR, this decision should be respected. This decision must be documented. Sections 12 and 13.

10. In the unlikely event a patient with a DNACPR decision suffers a reversible cause of cardiorespiratory arrest in circumstances not anticipated (e.g. choking or anaphylaxis in a care home or hospital); clinical judgement can override the DNACPR decision. Section 15.

11. DNACPR applies only to CPR and not to any other aspect of the patient’s treatment and care. Section 8.

12. Withholding CPR from patients based on blanket criteria such as age or disability is unethical and unlawful. Section 6.
CPR Decision Making Framework

- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully.
- Decisions should be reviewed regularly and always when circumstances change.
- Advice should be sought if there is uncertainty.
- Consensus MDT decisions are the preferred process.”

This section is not intended to be read in isolation but as a flow diagram to aid the process. Given the serious implications of CPR decision making, readers are urged to make time to read the whole policy and explore the guidelines and literature cited.
1.0 Purpose

1.1 The guidelines are for adults and young people aged 16 and over, please see the separate policy CPR – decisions relating to CPR section 11 Children and young people under 18 years of age.


1.2 It draws on best practice guidance and a recent Court of Appeal judgment to outline the legal basis and lawful process for not attempting Cardio Pulmonary Resuscitation (CPR) on an individual, and the factors to be weighed by GPs, consultants and other healthcare staff in making a decision about CPR status.

1.3 This is intended as guidance for all healthcare staff in the North and North East Lincolnshire area. It aims to achieve a coordinated approach to CPR decisions across all healthcare settings in the region – hospitals, general practice, care homes, the patient’s own home, hospices and the ambulance service – ensuring the patient’s best interests are met should their cardiac and/or respiratory function cease. It is not intended to be prescriptive, but recognises the very sensitive and unique nature of CPR decisions and the need to treat each case on an individual basis.

1.4 This is concerned only with CPR decisions and has no implication for any other clinical decisions relating to the patient’s care, such as drug and invasive therapies, hydration and nutrition. Even if a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision is made, all other care and treatment should continue as appropriate. The guidelines make no distinction between basic and advanced life support as the underlying principles are the same for both.

1.5 The guidelines aim to reflect the requirements of the Human Rights Act 1998, the Equality Act 2010, the Mental Capacity Act 2005 and its Code of Practice (2007) (1). It is based on the British Medical Association, Royal College of Nursing and Resuscitation Council (UK) Joint statement from the BMA/RCN and the Resuscitation Council (UK) 2007 (the Joint Statement) (3) and the recent Court of Appeal case of R (on the application of David Tracey) v Cambridge University Hospitals NHS FT [2014] EWCA Civ 822 (the Tracey case) (13). The guidelines should be read in conjunction with each agency’s relevant organisational policies and professional codes of practice (see Appendix A).

2.0 Guidelines Objectives

2.1 To avoid inappropriate resuscitation attempts by providing a framework for clinicians across the North and North East Lincolnshire area to identify patients for whom CPR is not assessed to be in their best interests.

2.2 To encourage and facilitate open, appropriate and realistic discussion around resuscitation decisions between staff, the patient and (if appropriate) those close to the patient, with the aim of understanding the patient’s wishes.

2.3 To ensure a standardised approach to documentation and communication around DNACPR decisions in health care settings in the North and North East Lincolnshire area.
2.4 To ensure all healthcare staff in healthcare settings across the North and North East Lincolnshire region are aware of any DNACPR decisions regarding their patients.

2.5 To ensure all healthcare staff feel confident with the process for taking decisions and for the involvement of the patient or their family/Relevant Other in all but exceptional cases.

2.6 To guide all healthcare staff caring for patients who lack capacity; have fluctuating capacity; or have communication difficulties in issues relating to CPR decisions.

3.0 Application (Including Area and Duties)

3.1 These guidelines apply to all areas of the North and North East Lincolnshire region where patients receive care across all settings including hospitals, GP practices, care homes and patients’ own homes.

3.2 These guidelines apply to all NHS healthcare professionals working in the North and North East Lincolnshire region.

3.3 Independent primary care contractors are expected to comply with the principles set out in these guidelines, in compliance with negotiated contracts.

3.4 Staff working in independent healthcare facilities, such as nursing and residential homes, are encouraged to comply with the principles set out in these guidelines.

3.5 It is hoped that other health professionals and nursing staff based in independent healthcare settings, for example residential and nursing homes, and hospices will seek the support of GPs and NHS nursing staff and use the standardised Yorkshire and Humber DNACPR form attached as Appendix C.

4.0 Introduction

4.1 The main principle of healthcare is to restore and maintain health so far as possible and by doing so, maximise benefit and minimise harm (3). It follows that for many patients in whom cardiac function and/or breathing has ceased, CPR is in their best interests and should be commenced immediately. However, prolonging life at all costs, with no consideration to the patient’s wishes, the potential burden of treatment on the patient and their subsequent quality of life, is not appropriate. As in the case of all treatments, the decision to deliver or withhold CPR should be driven by the principle of ensuring overall benefit for the individual patient, based on a balance of benefits, risk and burdens to the patient.
4.2 CPR is a medical therapy intended to restore and prolong life for patients whose cardiac and/or respiratory function has ceased (4). The Court of Appeal in the Tracey case described it as a: “violent and invasive physical treatment to attempt to maintain circulation and breathing of a patient whose heartbeat and/or breathing has stopped and to re-start the heart if possible. It involves repeated forceful compressions of the chest to a depth of 5-6 cm at a compression rate of 100-120 per minute, attempted inflation of the lungs by forcing air or oxygen into the lungs often through a tube inserted into a patient’s windpipe, the injection of drugs and the delivery of high voltage electric shocks (defibrillation) across the bare chest”. CPR carries risks of rib and/or sternal fracture, hepatic and/or splenic tears, brain damage and disability (3). Most patients surviving initial CPR are admitted to a CCU and/or ITU, where they will receive further invasive and potentially burdensome treatment. Despite this treatment many will not survive to be discharged from hospital. These potential consequences must be taken into account when making CPR decisions.

4.3 CPR can be highly effective when there is a single treatable cause, typically requiring a shock with a defibrillator, and appropriately trained staff able to respond promptly. Contrary to the relatively optimistic public perception, success rates of CPR (measured as the survival to discharge from hospital) remain relatively low. The Joint Statement confirms for arrests occurring in hospital survival to discharge is at best 15-20%. The National Cardiac Arrest Audit (NCAA) for 2010 reported that of 2614 non-shockable arrests (the most common in hospital) only 179 (7%) of patients survived to discharge from hospital (5). The survival rate out of hospital is, at best, 5-10% (6).

4.4 Despite the very poor prognosis of most cardiac arrests the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study “Time to Intervene” found that in the overwhelming majority of cases a DNACPR decision was not taken, reflecting an underlying assumption that cardiorespiratory arrest would result in CPR and a ‘last ditch attempt to prolong life’. (4). This might lead to a manner of death that the patient and those close to the patient would not have wished and would have breached their human right if a discussion had not taken place.

4.5 A DNACPR order records a prior decision that in the event of an individual patient suffering a cardiac and / or respiratory arrest, it would not be appropriate for CPR to be undertaken.

4.6 Sections 5.0 to 17.0 of these guidelines examine the process of making a CPR decision in the patient’s best interests, taking into account the factors that shape this decision.

Making CPR and DNA CPR decisions factors to consider:

5.0 When to consider a CPR decision

5.1 Making a CPR decision in a crisis, when there is insufficient time to involve people and to gather and consider relevant details, can be distressing for all involved. It is good practice in any healthcare setting to identify patients at an increased risk of cardiac or respiratory arrest and support them, in a sensitive and realistic manner, to reach a clear decision, in advance, about their wishes with respect to CPR as part of future care planning. These decisions take time, which needs to be factored into the process. In the case of patients who lack mental capacity this support should be extended to Relevant Others close to them, with a view to gaining insight into the patient’s wishes (the statutory framework for this process is set out in the Mental Capacity Act 2005 Code of Practice)(1).
5.2 The recent Court of Appeal judgment of R (on the application of David Tracey) v Cambridge University Hospitals NHS FT [2014] EWCA Civ 822 (the Tracey case) emphasised the importance of consultation with and involvement of patients in the DNACPR decision making process. Previously it was considered that where CPR was futile it was good practice to discuss this with a patient but not an essential requirement. However the court has now held patients should be informed about DNACPR decisions unless to do so would cause the patient physical or psychological harm.

5.3 It should be remembered that patients cannot insist on treatment which is not clinically recommended although in such circumstances a second opinion may be required. However this does not absolve the clinical team from the need to engage with the patient and/or their family and a second opinion may be required (for more on second opinions see sections 7.4 and 8.5).

5.4 If no advance decision or valid DNACPR decision is in place, and the express wishes of the patient are unknown, healthcare staff must use their clinical judgment and if appropriate commence CPR immediately in accordance with local resuscitation policy and training.

5.5 There will be some patients who have not made an advanced decision or do not have a valid DNACPR form in place but for whom CPR is clearly inappropriate at the time the health care professional is called to intervene, for example a patient discovered deceased with signs of rigor mortis. In such cases healthcare professionals who make a considered decision not to commence CPR should be supported by their senior colleagues and employers.

6.0 Non-discrimination

6.1 CPR decisions must be made on a sound understanding of each individual patient’s circumstances. Blanket policies denying CPR to specific groups of patients, such as those in a hospice or nursing home, for example, or to patients above a certain age or with a particular disability, are highly unethical and unlawful under the Equality Act 2010 and the Human Rights Act 1998.

6.2 The Equality Act 2010 prohibits direct and indirect discrimination against groups with certain “protected characteristics”. These protected characteristics include: age; disability; gender reassignment; marriage and civil partnership; race; religion or belief; sex and sexual orientation. Patients with any of the protected characteristics listed above must not be put at a disadvantage when compared against patients without the protected characteristic.

6.3 The Healthcare team must not base CPR decisions on pre-existing views about living with a particular condition, or assumptions based solely on the patient’s age, disability or on a subjective assessment of the patient’s quality of life. Decisions should be based on an objective assessment of what is in the patient’s best interests, taking into account all relevant factors and, most importantly, the patient’s own views (where these can be ascertained).
6.4 DNACPR decisions are significant from a Human Rights Act 1998 perspective and are likely to engage article 2 (right to life) article 3 (prohibition on torture, inhuman or degrading treatment or punishment) and article 8 (right to respect for private and family life) of the European Convention on Human Rights. There is a requirement on healthcare professionals to ensure DNACPR decisions are made in a procedurally fair and reasonable manner; therefore there is a presumption that patients will be consulted in the DNACPR decision making process unless clinician judges CPR would be clinically futile when the patient would be informed of the decision.

7.0 Circumstances where CPR is not clinically indicated/futile

7.1 If the GP/consultant/senior clinician believes that CPR will not restart the heart and maintain breathing i.e. it would be futile, it should not be attempted. However, the patient's individual circumstances and the most up to date clinical information must be carefully considered in reaching this decision.

7.2 The Court of Appeal in the Tracey case confirmed there is a presumption in favour of the patient being informed of DNACPR decisions even in cases of futility. There should be "convincing reasons not to involve the patient" i.e. if the clinician considered that informing the patient of the decision would cause physical or psychological harm.

7.3 Patients in the final stages of an incurable illness, when death is expected within days, are very unlikely to benefit from CPR and therefore fall within the category of futility. In some cases it may increase suffering and subject the patient to an undignified and traumatic death. Clinicians must consider a DNACPR decision as part of the care planning process for such patients.

7.4 Even where the clinician considers CPR will be futile, patients should still be informed of the decision. Patients cannot require CPR to be undertaken if the clinical view is that it is futile but the Court of Appeal considered it was important patients are informed of the decision so they may seek a second opinion, if desired.

7.5 The Court held:

"a decision to deprive the patient of potentially life-saving treatment is of a different order of significance ... the patient is entitled to know that such an important clinical decision has been taken. The fact that the clinicians considers that CPR will not work means that the patient cannot require him to provide it. It does not...mean that the patient is not entitled to know that the clinical decision has been taken. Secondly if the patient is not told that the clinician has made a DNACPR decision he will be deprived of the opportunity of seeking a second opinion."

8.0 Involvement in DNA CPR decisions

8.1 Guidance from the Court of Appeal, in the case of Tracey, confirms there is a presumption in favour of patient involvement in decisions regarding DNACPR/CPR. There needs to be convincing reasons not to involve the patient in the decision making. It may be inappropriate to involve a patient if the clinician believes to do so will cause the patient physical or psychological harm. The fact a patient may find the discussion distressing is not sufficient unless the distress will cause the patient harm.
8.2 Clinicians who consider a patient's involvement in DNACPR discussions will cause physical or psychological harm should be able to demonstrate the matter has been conscientiously considered. The decision should be clearly documented in the clinical notes alongside the information available, reasoning and the identity of those individuals taking the decision.

8.3 Where the patient indicates they do not wish to discuss CPR it is important to discuss the decision with his/her Relevant Others, provided the patient has consented to this information being shared. Patients may indicate, by their engagement with decision making previously, that they would prefer their family to have full involvement in all care planning about their end of life care. However patient consent to family involvement should be clearly documented in the records.

8.4 Healthcare professionals should not withhold making or communicating DNACPR decisions because they find it uncomfortable or difficult to discuss with patients. It is likely to be more distressing for patients and those close to them to discover by chance that a DNACPR decision has been made without their involvement.

8.5 Individuals with the authority to act on behalf of a patient lacking capacity, such as a welfare attorney with valid Lasting Power of Attorney, should be made aware of the DNACPR decision based on clinical futility and the reasons for it. If it is not a "clinical futility" case, but DNACPR is being considered by the clinical team, the welfare attorney/Relevant Other should be as involved as if this was a patient with capacity.

8.6 If a second opinion is requested, this should be provided. The Court of Appeal in the Tracey case placed great weight on patients having the opportunity to seek a second opinion if the clinical decision was against CPR.

8.7 It must be clearly explained to patients, Relevant Others of patients lacking capacity and healthcare staff that a DNACPR decision refers to CPR only, based on the clinical belief that it would not be successful or in the patient's best interests. A DNACPR decision does not apply to basic care or any other treatments and interventions. No other care or treatment is withheld as a result of a DNACPR decision. For example a patient with multi-organ failure secondary to severe sepsis may have a DNACPR decision in recognition that CPR is unlikely to be effective but will be admitted to ITU for mechanical ventilation, antibiotic therapy, inotropic therapy and haemofiltration, with the aim of saving their life. The BMA has issued advice on decisions to withdraw or withhold treatments that may prolong life (7).
9.0 Balanced decisions: balancing the overall benefit and risks in taking DNACPR decisions

9.1 In cases where CPR may be successful, the overall benefits for the patient of prolonging life must be weighed against the potential burdens. Such decisions are not solely clinical and must take into account the patient’s broader best interests including expressed or likely wishes. Discussions with patients, or Relevant Others close to a patient, who lacks capacity, should be realistic and sensitive and convey the potential risks and adverse effects of CPR in each individual’s particular circumstances. While healthcare professionals do not wish to alarm patients or deter them from accepting lifesaving treatment, it is essential that everyone involved in decision making is fully informed of the potential risks and outcome of CPR, so they may make an informed decision. Senior clinicians must ensure the patient’s wishes, feelings, beliefs and values are included in the careful consideration of all relevant factors when reaching a decision about CPR.

9.2 It is important to consider that if CPR is likely to be successful there may be potential burdens to the patient following CPR. The patient’s views on what is a tolerable level of suffering, disability and an acceptable life expectancy with such a burden will vary widely from person to person. This is a quality of life issue and the patient, or Relevant Others close to a patient who lacks capacity, should be informed and invited to discuss the risks and overall benefits of CPR.

9.3 A decision to attempt CPR does not mean all levels of intensive therapy and procedures are appropriate. A patient may survive initial CPR but is unlikely to benefit from treatments such as artificial ventilation, hemofiltration, and circulatory support with inotropic drugs. When discussing CPR decisions with patients and those Relevant Others close to a patient who lacks capacity, the likelihood of success of treatment beyond CPR must be explained in a sensitive but realistic manner.

9.4 Discussions with members of the community, hospice and hospital medical, nursing and therapy teams caring for the patient are valuable for gaining insights into the likely clinical effectiveness of attempting CPR and the overall benefit for patients who lack mental capacity. These views should be considered by senior clinician where possible.

10.0 Communication of benefit and risks of CPR decisions

10.1 When considering a CPR decision for a patient with capacity, where clinicians believe the benefits of CPR would be out-weighed by the burdens, or there is doubt whether the level of recovery would be acceptable to the patient, there should be a sensitive and honest exploration of the patient’s wishes, feelings, values and beliefs. Discussions with patients about CPR decisions must be clearly documented in their healthcare record.
10.2 Whilst the presumption is that patients should be involved in decision-making, information should not be forced on unwilling recipients. If patients indicate they do not wish to discuss CPR decisions this should be respected and the reasons why this discussion did not take place clearly documented in the patient record (see section 20 documentation below). If the patient is unwilling to engage in a discussion about CPR, he or she should be asked whether there is a family member that the clinical team can speak with. If the patient refuses consent for this, it should be recorded in the patient record.

10.3 In the case of patients who lack capacity, where the healthcare team believe the burdens of CPR may outweigh the benefits, sensitive and realistic discussions should be initiated with those Relevant Others close to, or representing, the patient. Only relevant information should be shared with those close to patients, unless the patient has given prior consent to full disclosure when they were competent to do so. The DNACPR form will reflect that discussion accordingly.

10.4 Care must be taken to ensure healthcare staff and those close to or responsible for a patient who lacks capacity, do not view the patient's quality of life from their own perspective when engaged in discussions about CPR; allowing their own wishes rather than the patient's to lead the decision making process. Complex and sensitive discussions should be guided by an experienced member of staff with a view to understanding what the patient would want were they able to speak for themselves and not what the healthcare team or person close to the patient would want if they were in the patient's position.

10.5 It is important to ensure that those close to or representing the patient understand that their role in discussions is to help inform the decision making process. **They have no legal authority and must never be placed in the position of having the final say on a CPR decision.** In accordance with the Mental Capacity Act 2005, the decision should be made by a senior healthcare professional, acting in a patient's best interests, following consultation with relevant others on what the patient would have wanted, if they had capacity. If there is no consensus opinion, legal advice may be required (see section 13.0 below).

11.0 Patient request for CPR where clinical judgment considers CPR futile

11.1 Patients (or Relevant Others close to, or responsible for, patients who lack capacity) may ask for CPR to be attempted, despite a clinical assessment that CPR would be futile. Neither patients nor their Relevant Others can demand treatment which is clinically inappropriate. Realistic information must be provided to the patient in a sensitive manner, including the risk of disability.

11.2 In the unusual situation where a doctor, having carefully explained the risks and benefits to the patient, feels unable to agree with the patient's expressed wishes in favour of CPR, or where the healthcare team have not reached agreement, a second opinion should urgently be sought so that patients may review their wishes in the light of further advice. In exceptional circumstances the patient's care can be transferred to another doctor or team. If despite this, disagreement is ongoing, it may be necessary to seek legal advice.
12.0 Patient refusal of CPR

12.1 Adults with capacity have the right to refuse any medical treatment, including the option of CPR, even if this decision may result in their death.

12.2 If, in the case of a patient at risk of cardiorespiratory arrest, the senior clinician and team believe CPR may succeed discussions should take place with the patient to determine their views and wishes regarding CPR. If the patient refuses CPR this decision should be documented in the healthcare record and communicated to those who need to know.

12.3 Although patients are not obliged to justify their reasons for refusing CPR, it is helpful to ensure the patient’s decision is based on accurate information, with no misunderstandings or misconceptions. Care must be taken by healthcare professionals not to pressure patients into accepting CPR against their wishes.

12.4 If a patient has made a valid and applicable Advance Decision refusing CPR this must be respected. A formal Advance Decision refusing CPR, which meets the criteria stipulated in the Mental Capacity Act 2005, is legally binding on the healthcare team (see Appendix B for more information about advanced decisions).

12.5 If an advance decision does not meet this criteria but appears to reflect the patient’s wishes, it should be taken into consideration when determining the patient’s best interests.

12.6 If a patient wishes to make an advanced decision refusing CPR, this should be explored in a sensitive and realistic manner by an experienced member of the healthcare team. Copies of advanced decisions should be kept at the front of the medical notes.

13.0 DNACPR decisions and mentally incapacitated patients

13.1 Patients over 16 years of age are presumed to have capacity to make their own decisions unless there is evidence to the contrary. Under the Mental Capacity Act 2005, patients are considered legally unable to make decisions for themselves if, at that time when the decision needs to be made, 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, or
- Communicate the decisions (whether by talking, using sign language, visual aids or by their means)

13.2 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 DNACPR Decision. An assessment of capacity must relate to; the specific decision the patient is being asked to make; their ability to comprehend their situation; and the implications of their decision according to the principles of the Mental Capacity Act (2005). Full guidance on establishing whether a patient has mental capacity can be found in the Mental Capacity Act [2005] Code of Practice (1).
13.3 Patients with welfare attorneys, court appointed deputy or guardian

13.3.1 A welfare attorney, a court appointed deputy or guardian must be consulted about CPR decisions. Provided the Lasting Power of Attorney document, appointing the welfare attorney, expressly provides the attorney with the power to make decisions on life sustaining treatment, then the welfare attorney has the legal right to make CPR decisions for a patient that lacks capacity. They are unable to demand inappropriate medical treatment on the patient's behalf i.e. when CPR would be futile. Where the patient is at risk of cardiac arrest and the CPR decision balances on the relative burdens and benefits, they should be consulted as they may offer insights into the patient’s likely wishes.

13.3.2 When there is a disagreement between the healthcare professional and the welfare attorney which cannot be resolved then an application to the Court of Protection may be necessary and legal advice should be sought.

13.4 Patients without welfare attorney, deputy guardian or advance decision but with family and friends

13.4.1 When a patient who lacks capacity is at risk of cardiorespiratory arrest and there are doubts about the balance of risks and benefits of CPR, discussions should be held with Relevant Others close to the patient with a view to gaining insight into the patient’s likely wishes.

13.4.2 It should be made clear to family members and friends that they cannot take decision on behalf of the patient; their role is to help the healthcare team take a decision in the patient's best interests. The most senior clinician in charge of the patient's care is responsible for taking the CPR decision in the patient's best interests.

13.4.3 When there is a disagreement between the healthcare professional and family which cannot be resolved then an application to the Court of Protection may be necessary and legal advice should be sought.

13.5 Patients with no welfare attorney, family friends or other advocates

13.5.1 In the case of patients who lack capacity and have no appropriate family, friends or other advocates to consult with regards to CPR decisions, the Mental Capacity Act (2005) requires that an independent mental capacity advocate (IMCA) must be involved in all decisions about "serious medical treatment". The IMCA does not have the power to make decision but must be consulted as part of the clinician's best interest decision. To ensure fair process in CPR decisions and compliance with the Human Rights Act 1998 and Mental Capacity Act 2005, it is recommended (where practical) an IMCA should be consulted in all circumstances even if CPR is considered futile. If a decision is needed when an IMCA is not available (i.e. night time) then the decision should be made and recorded and discussed with an IMCA at the first opportunity.
14.0 Conditions on DNACPR forms

14.1 Clinicians outside ITU settings sometimes restrict CPR to the treatment of shockable rhythms only, as these are more likely to respond well to simple treatment. Such decisions are subject to the balance of risks and overall benefit to the patient and should be discussed with the patient or Relevant Others (if the patient lacks capacity). The reasons for limiting the nature or extent of CPR should be documented fully in the patient’s notes and all members of the healthcare team briefed.

14.2 Advanced decisions about the duration of CPR are not recommended. The decision on when to stop resuscitation is best made by the resuscitation team, based on an assessment of the perceived balance of benefits and burdens of continuing CPR to the patient.

15.0 Urgent medical treatment and planned procedures once DNACPR is in place

15.1 Rarely patients with a DNACPR order may develop a readily reversible cause for cardiac or respiratory arrest, for example choking, anaphylaxis or a blocked tracheostomy tube. In such cases appropriate resuscitation interventions should be attempted, unless the patient has specifically refused CPR in these circumstances.

15.2 Patients with a DNACPR order may undergo a procedure with an increased risk of cardiorespiratory arrests, where the cause of arrest is readily reversible e.g. coronary catheterisation or surgery under general anaesthetic. DNACPR decisions should be reviewed prior to the procedure, ideally involving a discussion with the patient or their representative if the patient lacks mental capacity. The DNACPR decision may be suspended temporarily for the duration of the procedure and reinstated at an agreed time or may remain in place.

16.0 Young people aged 16 and 17 years – special considerations

16.1 The Association for Children’s Palliative Care (8) recommends that every young person with a life limiting condition should be helped, with their family, to decide on an end of life or palliative care plan.

16.2 It may 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 helpful to begin discussions if a young person has an acute illness or repeated illness and the healthcare team and/or parents feel the terminal stage is approaching, or the young person is thought to be at an increased risk of a sudden life threatening illness or event. Usually the most appropriate professional to initiate this discussion is the named paediatrician or palliative care practitioner.
16.3 If professionals initiate discussion about end of life decisions, consideration should be given to the sensitive timing of this and 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 CPR and the young person/family indicate they do not wish to continue, their wishes should be respected and the details recorded in the young person’s medical and nursing record. Discussion may also be initiated by the young person or family at any time.

16.4 Who can make a CPR decision in the case of a 16 to 17 year old

16.4.1 The Department of Health, Reference Guide to Consent for Examination or Treatment, (2009) states 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 (9).

16.4.2 As for adults, a young person is presumed to have capacity to consent to treatment unless the contrary is shown. To establish whether a young person aged 16 or 17 has the capacity to effectively agree not to receive CPR; the same criteria should be used as for adults. The Mental Capacity Act 2005 (section 2 (1)) will apply in the same way as it does to those who are 18 and over (9).

16.4.3 An individual with parental responsibility for a young person aged 16 or 17 who lacks capacity may make a CPR decision where they consider it to be in the young person’s best interests. However, if the Healthcare team disagree with the decision, legal advice should be sought.

16.4.4 Refusal of treatment by competent young people is not necessarily binding upon clinicians as consent from those with parental responsibility or the court itself allows clinicians to provide treatment. It is good practice to involve the young person’s family in the decision-making process, providing he/she consent to this information being shared.

16.4.5 If a young person 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.

16.4.6 If a young person does not wish to be resuscitated and the family or the healthcare team disagree, then legal advice should be sought as a Court Order may be required.

16.5 Safeguarding issues

16.5.1 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 (see Appendix E for more details on parental responsibility in 16–17 year olds).

16.5.2 For children 15 years and younger – refer to a separate policy entitled decisions relating to cardio pulmonary resuscitation.
Sections 17.0 to 25.0 of the guidelines focuses on the responsibilities of healthcare professionals in relation to CPR decisions

17.0 Responsibilities of North and North East Lincolnshire Healthcare professionals

17.1 Overall responsibility for this policy:

- Northern Lincolnshire and Goole NHS Foundation Trust:
  - Medical Director - Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

- Community:
  - Medical Director – Northern Lincolnshire and Goole NHS Foundation Trust for community based staff employed by (NLAG)
  - Medical Director – Lindsey Lodge Hospice
  - Medical Director – St Andrew’s Hospice
  - Medical Director – CCG GP North and North East Lincolnshire
  - Medical Director – CPG

17.2 Clinical responsibility for making DNACPR decision

17.2.1 Hospitals of Northern Lincolnshire and Goole NHS Foundation Trust:

17.2.2 The hospital consultant will be responsible for making DNACPR decisions in hospital and 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 may be delegated to another member of the healthcare team, but it should be clear who has this responsibility and how this will be fulfilled.

17.2.3 In the absence of the consultant DNACPR decisions can be made by the consultant’s deputy (i.e. Specialist Registrar (ST/CT 3 or above) or speciality doctor). A decision made by the consultant’s deputy must be countersigned by the consultant at the earliest opportunity.

17.2.4 In exceptional circumstances a DNACPR decision can be made by an ST/CT 2 doctor but this must be reviewed by the consultant or consultant’s deputy at the earliest opportunity and in any event within 24 hours.
17.2.5 **ST/CT1 doctors, foundation year doctors** and, with the exception of **appropriate RNs registered nurses** must not make a DNACPR decision, but should consider the DNACPR status of patients and discuss any appropriate cases with the clinician with overall responsibility for the patient. CPR decisions may arise in discussions with patients (or Relevant Others close to, or responsible for, a patient who lacks capacity) which state or give insight into the patient’s wishes. In such cases document the key points of the discussion and discuss with the clinician with overall responsibility for the patient or their deputy as soon as possible.

17.2.6 The **ward manager** is responsible for ensuring that every DNACPR 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.

17.2.7 The **nurse** responsible for the patient’s discharge must ensure all relevant information and the DNACPR regional form is disseminated appropriately, to ensure continuity of care at all stages of the patients move back into the community.

17.2.8 Other **healthcare professionals**, for example community and hospital based therapists, are responsible for ensuring DNACPR decisions are recorded in their notes and communicated to colleagues caring for the patient.

17.2.9 **Community, North and North East Lincolnshire:**

17.2.10 The patient’s GP/senior clinician (in some sectors this could be a senior nurse with appropriate training) will be responsible for making DNACPR decisions in the community and ensuring the decision is communicated effectively to all members of the multidisciplinary team and the hospital in the event of admission or referral. 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 this responsibility.

17.2.11 The senior clinician is responsible for ensuring that every DNACPR decision is recorded in their records, read coded and scanned in to the patient’s electronic records.

17.2.12 Other healthcare professionals, for example community therapists, are responsible for ensuring DNACPR decisions are recorded in their notes (if not using multidisciplinary notes) and communicated to colleagues caring for the patient.

17.3 **Responsibility for communication**

17.3.1 Overall responsibility for decision making is specified in section 17.2 above. This person should be prepared to discuss a DNACPR decision with the patient, or Relevant Others close to the patient, and other members of the healthcare team. Teamwork and good communication is essential to patient-centred CPR decision making. Where care is shared between the hospital and the community, those with overall responsibility for the patient’s care e.g. senior clinician should share the CPR decisions with other members of the healthcare team.

17.3.2 There should be a shared approach when considering DNACPR decisions and discussing the issue with patients and Relevant Others for patients who lacks capacity. However, while a shared approach is encouraged one person should be responsible for ensuring the decision is made properly, is accurately recorded and communicated to all who need to know, both in the community and hospital.
18.0 Patient confidentiality

18.1 If patients have capacity to make decisions their permission must be sought before sharing information with those close to them. As a part of advance planning it may be helpful to ask patients with capacity who they would want and not want involved in decision making if they become incapacitated. Refusal by a patient with capacity to allow disclosure of information to friends and family must be respected (see Section 16 in respect of young people aged 16 and 17 years).

18.2 For patients lacking capacity senior clinicians may share only that confidential information with those close to a patient provided it is not contrary to the patient's interests or previously stated wishes and limited to information strictly necessary. Relevant information should be provided to welfare attorneys, deputies or guardians, so they are better able to fulfil their role. IMCAs have a legal right to information, to enable them to carry out their statutory role.

19.0 Information for patients

19.1 Written information about DNACPR decisions should be made available to patients and those Relevant Others close to them as part of the general literature provided by hospitals, general practice, ambulance services, hospices and care homes. The aim is to de-mystify the process by which DNACPR decisions are reached. Information should help reassure patients of their role in decision making and encourage them and Relevant Others close to them to approach the healthcare team with questions about DNACPR decisions.

19.2 Written information is also important to inform the patient of the criteria used to reach the DNACPR decision.

19.3 There is a DNACPR decision information leaflets available for use in the Northern Lincolnshire region:

- What Happens if my Heart Stops (11) Available on the Medical Director Intranet Site for Northern Lincolnshire and Goole NHS Foundation Trust:
  

20.0 Documenting DNACPR Decisions

20.1 DNACPR forms are to be completed in hospital in triplicate with the patient to retain the first copy. A second copy is filed in the hospital medical notes. A third copy is forwarded to clinical audit (hospital only). As patients move between care settings, (e.g. hospital to care home or patient's own home or hospital to hospital) the DNACPR form top copy moves with the patient in a clearly marked envelope. DNACPR forms completed in the community need to be read coded on SystmOne and scanned into the patient electronic records.
20.2 All DNACPR decisions made for patients of 16 years and over must be recorded on the *Yorkshire and Humber Regional Form* (see Appendix C below) and a record of the discussion also included in medical records. The regional form is designed to help ensure continuity of DNACPR decisions across primary and secondary care organisations, with the aim of safeguarding the patient’s best interest in the event of cardiorespiratory arrest.

20.3 If a blank form is photocopied for use it is still valid, despite the loss of the red border, providing the form is filled in by hand by the person responsible for making a DNACPR decision. If using a photocopied black and white DNACPR regional form then it is helpful to complete in blue ink if possible, to make differentiating the completed form from a photocopy simpler.

20.4 *Photocopies of completed DNACPR forms are not valid* – If a photocopy is presented by the patient or Relevant Other full consideration must be given to the patient’s wishes; while not valid a photocopied DNACPR should initiate discussion about the patient’s views with respect to CPR decisions.

20.5 The task of disseminating information about the decision to others providing care to the patient may be delegated from the decision maker to another member of the healthcare team, but it should be clear who has this responsibility.

20.6 The CPR decision and the circumstances surrounding the decision must also be clearly recorded in the patient’s medical and nursing notes (if separate). It should clearly record whether the patient has capacity and if so what their decision was. If the patient lacks capacity the note should record who was consulted as part of the Best Interest the decision making process (patient, healthcare professionals, family and friends, welfare attorneys, deputies and guardians and IMCA).

20.7 The term *Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)* must be used in all medical records.

20.8 The registered nurse responsible for the patient’s care must ensure that the DNACPR 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.

20.9 Other healthcare professionals, for example hospice staff or community and hospital based therapists, are responsible for ensuring DNACPR decisions are recorded in their notes (if not using multidisciplinary or medical notes) and communicated to colleagues caring for the patient.

20.10 Whilst in Hospital, the DNACPR form will remain in the front of the patient’s medical notes. In all other care settings the DNACPR form must 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 relevant health care professionals. This arrangement must be clarified when handing the form to the patient/family/carer by the registered nurse/other healthcare professional responsible for the discharge/transfer of the patient.

20.11 To cancel a DNACPR form, 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.
21.0 Key actions on admission, transfer or discharge: communicating with other healthcare professionals

21.1 Whenever a patient is transferred between establishments, departments or discharged home it is essential that DNACPR decisions are communicated between all who need to know in a discreet and sensitive manner. This includes the ambulance crew and the receiving organisation/team or out of hours service. The DNACPR decision must also be communicated to the members of an oncoming shift or on-call team caring for the patient.

21.2 In circumstances where the patient is being transferred, the registered nurse/other health care professional responsible for the patient's care will inform the patient (where appropriate) and Relevant Others of the DNACPR regional form.

21.3 Ambulance control is informed by the registered nurse/other health care professional responsible for co-ordinating the patient’s transfer that a DNACPR form exists at the time of booking a patient transport services (PTS) ambulance or an ambulance crew.

21.4 The registered nurse/other health care professional responsible for co-ordinating the patient’s discharge/transfer from a healthcare 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.

21.5 If an ambulance is called in an emergency and the patient requires transferring to A&E (or Emergency Care Centre (ECC) Diana, Princess of Wales Hospital, Grimsby), i.e. from a community health setting 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 inside. On arrival at the care setting the crew will formally hand-over the DNACPR form to the member of staff responsible for receiving the patient.

22.0 Review of a DNACPR decision

22.1 Review of DNACPR status by the senior clinician consultant (or his/her deputy) should always take place when there is a change in the patient’s circumstances.

22.2 The circumstances surrounding the decision and the decision making process must be clearly recorded in the patient’s medical and nursing notes (if separate), together with who was involved in the decision making process.

22.3 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 this responsibility.

22.4 Review of DNACPR decisions should take place in the following circumstances:

- A change in the patient’s wishes, (this would involve a face to face contact/decision)

- On transfer of Medical Responsibility

- Whenever there are significant changes in the patient's condition or care plan in the opinion of the senior clinician
• If the person responsible for a DNACPR decision wishes to review that decision on a specific date in the future, Section 3 of the Yorkshire and Humber Regional DNACPR form must be completed and the reasons and outcomes of the review entered in the patient’s medical and nursing notes.

• It is not necessary to enter discussion with the patient/Relevant others every time a decision is reviewed unless it is likely the decision will be revised. It is essential to discuss changes to CPR status with patients, or Relevant Others in the case of a patient who lacks capacity.

### 23.0 Monitoring Compliance and Effectiveness

23.1 **In hospital** – Data will be audited every 6 months and made available to the Trust board, clinical directors and national bodies such as the CQC and NHSLA assessing the Trust. See Appendix D for a copy of the audit standards.

23.2 A random sample of DNACPR orders will be audited. The bottom (3rd) copy of the DNACPR Yorkshire and Humber Regional form is to be sent to the Quality and Audit Department in a sealed envelope marked ‘confidential’.

23.3 **In the community** – Data will be audited every 6 months.

### 24.0 Training

24.1 **In hospital (and community staff in North Lincolnshire employed by NLAG)**

24.1.1 Mandatory resuscitation training will include CPR decision making training for all relevant professional groups. The scope of the training will be determined by the anticipated involvement in CPR decisions of those attending the course. For some staff, such as HCAs and most Allied Health Professionals, training may involve making staff aware of the form, how it should be stored and what to do if a patient with a valid DNACPR decision collapses or raises the question of CPR decisions. With RNs and doctors the form will be discussed in greater detail in accordance with these guidelines.

24.1.2 Senior nurses who are involved in CPR discussions with patients and families will be required to have training including communication skills.

24.2 The following training resources will be available online:

• **Links to DNACPR webcast:**
  
  • **Scenario 1:**
    
    [http://nlqnet.nlg.nhs.uk/PR.Communincations/Videos/DNA%20CPR%20Scenario%201.wmv](http://nlqnet.nlg.nhs.uk/PR.Communincations/Videos/DNA%20CPR%20Scenario%201.wmv)
  
  • **Scenario 2:**
    
25.0 Definitions

25.1 Cardiorespiratory arrest – Cessation of cardiac and respiratory function.

25.2 CPR – A treatment undertaken for a patient in cardiorespiratory arrest with the aim of restoring breathing (sometimes with support) and spontaneous circulation.

25.3 DNACPR – Do not attempt cardiopulmonary resuscitation – A decision not to attempt CPR in a patient who suffers cardiorespiratory arrest.

25.4 Senior clinician – Consultants, GP, hospice doctors, appropriate registered nurses e.g. community matrons, community Macmillan palliative care nurses (all to have had appropriate training).

25.5 Relevant Others – People close to the patient who lacks capacity who should be consulted. Section 4(7) of the Mental Capacity Act 2005 states the following people should be consulted: anyone named by the patient as someone to be consulted; carers or those interested in the patient's welfare, anyone holding a lasting power of attorney; and any court appointed deputy.

25.6 Welfare attorney – anyone holding a valid registered personal welfare lasting power of attorney.

26.0 References / Associated Documents


   http://www.resus.org.uk/pages/dnar.htm

   http://www.ncepod.org.uk/2012cap.htm


27.0 Consultation

27.1 Rachel Hewison, Senior Resuscitation Officer, Northern Lincolnshire and Goole NHS Foundation Trust.

27.2 Dr Ann Morris, Lindsey Lodge Hospice, Medical Director Lindsey Lodge Hospice.

27.3 Denise Drinkall, Commissioning Support, North Yorkshire and Humber Commissioning Support Unit.

27.4 Michael Griffiths, Named Nurse Safeguarding, Northern Lincolnshire and Goole NHS Foundation Trust.

27.5 Helen Mumby, Macmillan EOL lead nurse – Community, Northern Lincolnshire and Goole NHS Foundation Trust.

27.6 Jackie Smith, Palliative Care Nurse, Northern Lincolnshire and Goole NHS Foundation Trust.

27.7 Val Revill, Macmillan Lead Nurse for Palliative Care and End of Life Care, Care Plus Group North East Lincolnshire.

27.8 Wendy Swan, Community Macmillan Nurse, Northern Lincolnshire and Goole NHS Foundation Trust.

27.9 Claire Quinn, Solicitor: Healthcare Regulatory, On Behalf of DAC Beachcroft LLP.

27.10 Craig Ferris, Head of Safeguarding, Northern Lincolnshire and Goole NHS Foundation Trust.
27.11 Alan Lees, EOL Lead GP, Care Commissioning Group.

27.12 Guy Hageman, Resuscitation Officer, Northern Lincolnshire and Goole NHS Foundation Trust.

27.13 Jason Boland, Specialist Palliative Care Consultant, Care Plus Group North East Lincolnshire.

28.0 Equality Act (2010)

28.1 In accordance with the Equality Act (2010), the Trust will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Trust will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

28.2 The Trust will wherever practical make adjustments as deemed reasonable in light of an employee’s specific circumstances and the Trust’s available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).
Appendix A

Organisational Policies and Professional Codes of Conduct

1. Professional Codes of Practice:

   - Nursing and Midwifery Council (NMC): The code: Standards of conduct, performance and ethics for nurses and midwives

   - General Medical Council (GMC): Standards and ethics guidance for doctors
     http://www.gmc-uk.org/guidance/good_medical_practice.asp

   - Health and Care Professions Council (HCPC): Regulating health, psychological and social work professionals
     http://www.hpc-uk.org/

2. Organisational Policies:

   i) Northern Lincolnshire and Goole NHS Foundation Trust:

      - Resuscitation Policy

      - Consent
        http://nlgnet.nlg.nhs.uk/DocumentControl/Documents/Policy%20for%20Consent%20to%20Examination%20or%20Treatment%20(DCP008).pdf

      - Safeguarding Adults

      - Safeguarding Children

      - Equality and Diversity
Appendix B

Advance Statements, Advance Directives and Living Wills
(Adapted from the Bradford and Airedale Joint DNACPR policy (10))

1. **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 DNA CPR 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.

2. **Advance Decision (may sometimes be referred to as a Living Will)**

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:

• Request anything that is illegal such as euthanasia or for help to commit suicide

• Demand any treatment that is contrary to the clinical judgment of the healthcare team

• 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:


British Medical Association: www.bma.org.uk

General Medical Council: www.gmc-uk.org

Patients Association : www.patients-association.com

Terrance Higgins Trust: www.tth.org.uk

Alzheimer’s Society: http://www.alzheimers.org.uk/factsheet/463

Motor Neurone Disease Association: www.mndassociation.org
Appendix C

Yorkshire and Humber Regional DNACPR Form

Page 1

Northern Lincolnshire and Goole NHS

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION
Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over

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: Address: Relationship:
Postcode: Date of Birth: Telephone No:

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.

B. [ ] CPR is against the wishes of the patient as recorded in a valid advance decision.
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:
   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:

   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: ___________________________

   ii) DNACPR decision is to remain valid until end of life [ ]

Section 3 – Healthcare professionals completing DNACPR Form (Guidance overleaf)

Date: ___________________________ Time: ___________________________

Print name: ___________________________ Print: ___________________________

Designation & Organisation: ___________________________
GMC / NMC No: ___________________________

Top Copy: To accompany the patient (see over)
Middle Copy: To be filed in the front of the Current Admission Sheet in the patient’s notes
Bottom Copy: Send to Clinical Audit

Printed copies valid only if separately controlled
NB: Section 1(c) – if there is no discussion with the patient or significant others, this should be documented and the reason recorded.

Yorkshire and Humber Regional DNACPR Form
Page 2 Guidance for Completion

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.

Option C
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.

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

1. The decision will only be valid if the patient is able to give consent at the time of the procedure, or if the patient's ability to give consent has been compromised by reasons such as the nature of the procedure, or the patient's medical condition.
2. The decision will only be valid if the patient is able to give consent at the time of the procedure, or if the patient's ability to give consent has been compromised by reasons such as the nature of the procedure, or the patient's medical condition.

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.

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 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. Where patients are being transferred to other care settings, 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.
3. For discharges to community settings, communicate to the GP. Out of Hours service and any other relevant services as appropriate.
*Note: Where the form is no longer valid, the form should be cancelled as outlined in section 2 above and the top and middle copies of the form should be filed in the patient’s notes.
## Appendix D

### DNACPR Audit Standards – Acute (Multi-Speciality)

<table>
<thead>
<tr>
<th>Threshold for Actions</th>
<th>Standards</th>
<th>Discipline Lead (with responsibility for change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>The decision for DNACPR should be made by the Consultant or the deputy in charge of the patient’s care.</td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>Where a DNACPR Order has been made in an emergency situation by a middle grade doctor or equivalent, then this decision <strong>must</strong> be reviewed by the Consultant or deputy at the earliest opportunity. <em>(within 24 hours)</em></td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>DNACPR discussions, decisions and the reason behind these decisions should be fully documented, signed and dated in the patient’s healthcare record.</td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>There should be clear documentation to state whether the patient had capacity to make the decision regarding DNACPR.</td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>If a patient lacks capacity to make the decision regarding DNACPR, that assessment must be documented, together with details of those consulted as part of the best interests’ decision making process.</td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>Where a DNACPR Order is made and there has been no discussion with the patient because he or she has indicated a clear desire to avoid such a discussion, this must be documented in the health records and the reasons given. <em>(Capable Patients only).</em></td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>Where a patient has a valid and applicable Advance Decision which refuses CPR, a copy of this should be filed in the patient’s healthcare record.</td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
<tr>
<td>100%</td>
<td>To avoid confusion regarding other appropriate treatment, the expression “not for cardiopulmonary resuscitation” should be used and clearly documented in the patient’s records.</td>
<td>Dr M Withers / Wendy Booth</td>
</tr>
</tbody>
</table>

### Additional Information to be collected

- Review of DNACPR Decision
- Number of patients discharged with a DNACPR Order in place
- Number of patients who died with a DNACPR Order in place
- Length between admission date and date of death
- Length between DNACPR Order date and date of death/discharge
- Indication for DNAR Order being applied
- Completion of patient details on the DNACPR form

Note: The above standards may be subject to change depending on the results of any pilot audits or as part of project planning.
Appendix E

Parental Responsibility – Who has it and what is it?
(Adapted from the Bradford and Airedale Joint DNACPR policy (10))

1. 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:
  - Are named on the child's birth certificate
  - 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

2. 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.

3. What happens when a young person and a person with parental responsibility disagree about a DNACPR decision?

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.

4. 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.

5. 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.

6. 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.