

PROCEDURE: DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

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PROCEDURE SUMMARY	
This procedure is to provide guidance to all staff working within Essex Partnership University NHS Foundation Trust regarding the process of making, recording and reviewing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.	
The Trust monitors the implementation of and compliance with this procedure in the following ways;	
Through the Resuscitation and Deteriorating Patient Group who will review audit findings and clinical incident reports as appropriate.	

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

**The Director responsible for monitoring and reviewing this procedure is
Executive Nurse**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

**DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION
PROCEDURE**

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)
PROCEDURE****1.0 INTRODUCTION**

- 1.1 Cardiopulmonary resuscitation (CPR - attempting to restart the heart and breathing) can be attempted on any person in whom cardiac or respiratory functions have ceased (also referred to as a cardiac or respiratory arrest). Failure of these functions is part of dying and thus CPR can theoretically be attempted on any individual as part of an attempt to preserve life. However, because there comes a time when death is inevitable for every person, it is essential to identify patients for whom cardiopulmonary arrest represents a final event in their illness and in whom attempted CPR may be inappropriate. It is also essential to identify those patients who do not want CPR to be initiated.
- 1.2 It must be emphasised that every patient (and/or their family), for whom a DNACPR decision is considered, must be given the opportunity to be involved in the decision-making process, and be informed of the decision unless this would cause them harm, or they have stated that they do not wish to be involved or informed. This policy does not distinguish between basic and advanced resuscitation since the underlying ethical and legal principles about how decisions should be reached are the same.
- 1.3 It is most important however, that it is understood that a decision not to commence CPR does not in any way diminish the importance of on-going medical and nursing care. The change of focus of care should be effected by those involved in managing the patient and should be assisted by the appropriate palliative care.
- 1.4 It must be emphasised that the implementation of a DNACPR decision relates solely to the withholding of artificial ventilation and delivery of chest compressions to a person in cardiac arrest. All other treatments and interventions deemed appropriate will be given. The responsibility for making decisions about resuscitation lies with the Consultant or General Practitioner (GP) in charge of the patient's care.
- 1.5 Where a valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is not available in the Medical records (or appropriate location) and the precise wishes of the patient are unknown, cardiopulmonary resuscitation should be initiated if cardiac or respiratory arrest occurs.

2.0 SCOPE

- 2.1 This procedure applies to all staff (including voluntary workers, students, locum and agency workers) on all sites, within EPUT.

3.0 LEGAL ISSUES

- 3.1 In order to meet their obligations under the Human Rights Act (1998), health professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempted CPR include:

- The right to life (Article 2).
- To be free from inhumane or degrading treatment (Article 3).
- Respect for privacy and family life (Article 8).
- Freedom of expression, which includes the right to hold opinions and to receive information (Article 10).
- Freedom from discriminatory practises in respect of these rights (Article 14).

- 3.2 If any concerns arise regarding the application of a DNACPR order, the senior doctor in charge of the patient's care should be informed. If concerns still exist, the Medical Director should be informed and the advice of the Trust's legal advisors should be sought.

4.0 DNACPR DECISION

- 4.1 The British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

- Where the individual's condition indicates that effective CPR is unlikely to be successful
- When CPR is likely to be followed by a length and quality of life not acceptable to the individual
- Where CPR is not in accord with the recorded, sustained wishes of an individual who is deemed mentally competent or who has a valid applicable ADRT.

- 4.2 It is recommended that early decisions about CPR status and advance planning about limits of care should be made when patients are at risk of a cardiorespiratory arrest and there should be a clear and explicit resuscitation plan. In particular, consideration of this should be given to patients on older adult wards.

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

- 4.4 If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, health professionals will commence CPR in the event of a cardiac or respiratory arrest as per CPR Policy.
- 4.5 There may be some situations in which CPR is commenced on this basis, but during the resuscitation attempt further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR decision, or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.
- 4.6 When considering making a DNACPR decision for an individual it is important to consider the following:
- Is cardiac or respiratory arrest a clear possibility for this individual? If not, it may not be necessary to initiate discussion with the patient.
 - If cardiac or respiratory arrest is a clear possibility for the individual, and CPR may be successful, will it be followed by a quality of life that would not be of overall benefit to the person? The person's views and wishes in this situation are essential and must be respected. If the person lacks capacity, a LPA will make the decision. If a LPA has not been appointed a best interests decision will be made.
 - If the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual
- 4.7 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:
- The DNACPR decision is made following discussion with patient/others, this must be documented in the patient's medical notes and a clear and explicit resuscitation plan developed.
 - The DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this, then a discussion with relatives/carers should only take place with the patient's permission. All discussions and decisions, including rationale must be clearly documented in the patient's records.
 - If a discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, the reason for this must be clearly documented in the patient's medical notes.

5.0 DOCUMENTATION

- 5.1 Any decision relating to resuscitation must be communicated to the entire team of health professionals caring for that patient. A DNACPR decision should be reviewed on each transfer of care, but remains valid until it is reviewed.
- 5.2 The senior doctor is responsible for writing and authorising the order, then informing relevant clinical staff (e.g. nursing teams, other departments, and those areas required to be aware) that the order is in existence.
- 5.3 If a DNACPR decision is made, the doctor in charge of the patient's care (i.e. Consultant or GP) is responsible for ensuring that the DNACPR form is completed (as per Appendix 2) and the printed, signed original form is retained in the front of the patient's notes. Where the facility exists, a copy should be scanned onto the electronic patient record, for audit purposes.
- 5.4 If the patient is discharged or transferred to another healthcare establishment, whilst still subject to a DNACPR, the original DNACPR form **MUST** accompany the patient at all times.
- 5.4.1. Information needed on a DNACPR order:
- Patient's details.
 - Date of decision.
 - Assessment of patient's capacity.
 - Clinical reasons for decision.
 - Summary of communication regarding the decision with patient or their Attorney.
 - Summary of communication with patient's relatives or significant others.
 - Names of multi-disciplinary team members contributing to the decision.
 - Name, position and signature of healthcare professional completing the decision.
 - Review and endorsement by doctor in charge of the patient's care (Consultant or GP).
- 5.5 The original DNACPR form must be stored safely in the most appropriate place for the particular clinical environment. Where a physical set of notes exists, the DNACPR form should be filed at the front, however where electronic patient records are in existence an alternative system such as a 'DNACPR folder' should be agreed. Wherever the form is stored it must be immediately available in the case of an emergency.
- 5.6 In the community the DNACPR form should be kept safely in the patient's home and be accessible to all staff involved in their care. All staff should be aware of its existence. It is essential that the form goes with the patient when undergoing hospital treatment and is returned to them on discharge.

6.0 REVIEWING A DNACPR

- 6.1 The DNACPR decision will be regarded as **'indefinite'** unless:
- A definite review date is specified
 - There are improvements in the patient's condition
 - The patient's express wishes change

The frequency of review should be determined by the health care professional in charge of the individual's care.

- 6.2 It is important to note that the patient's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR is reviewed, the clinician must consider whether the person can contribute to the decision-making process each time. It is not usually necessary to discuss CPR with the person each time the decision is reviewed, if they are involved in the initial decision. Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.
- 6.3 Prior to discharge from an in-patient facility, all DNACPR decisions should be reviewed and if the decision is to remain valid on discharge this needs to be communicated to the GP and community staff involved in providing support on discharge.

7.0 CANCELLATION OF DNACPR

- 7.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision by a doctor ST3 grade or above. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point pen and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional cancelling the order.
- 7.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision. The DNACPR form is then folded in half and filed at the back of the patient's medical notes.
- 7.3 If a copy of the DNACPR form is kept in the electronic patient records and the DNACPR decision is cancelled or suspended then the record must be updated to reflect this and steps must be taken to ensure that the DNACPR form does not appear to remain as a live document. For example on Mobius a request should be made to move the form to historical alerts via the 'report a problem' facility and a reason given. This should be done at the same time as scanning a copy of the 'cancelled' document.

8.0 SUSPENSION OF DNACPR

- 8.1 Uncommonly, some patients for whom a DNACPR decision has been established may have a cardiac or respiratory arrest from a readily reversible cause. In such situations CPR would be appropriate, whilst the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. It may

therefore be appropriate and necessary to ignore or override a DNACPR order or an ADRT and give treatment and/or resuscitation in such circumstances such as anaphylaxis or choking.

- 8.2 Some procedures could precipitate a cardiac or respiratory arrest, for example, induction of anaesthesia, surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the patient where applicable, will need to take place.
- 8.3 If a DNACPR decision is made on medical grounds, not in relation to a mental health condition and a person attempts to end their life, every reasonable attempt should be made to resuscitate the individual in this situation as the DNACPR form was not completed with the eventuality of suicide in mind.

9.0 LACK OF AGREEMENT

- 9.1 A patient with Capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an Advanced Decision to Refuse Treatment (ADRT). An ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the ADRT, but it is not essential. If the patient had capacity prior to a cardiac arrest event, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. The verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The patient should be encouraged to make an ADRT to ensure the verbal refusal is adhered to.
- 9.2 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a DNACPR form in their possession. An appropriate sensitive discussion with the patient should aim to secure their understanding and acceptance of the DNACPR decision. Fully documented discussion with relevant multi-disciplinary team members and family where possible would provide evidence of best practice. Additionally a second opinion may be sought in some circumstances.
- 9.3 Individuals do not have a right to demand that doctors carry out treatment against their clinical judgment. It may arise in rare cases that a clinical decision is seriously challenged and agreement cannot be reached, in these circumstances legal advice may be indicated.

10.0 PATIENTS WHO LACK CAPACITY

- 10.1 A person must be assumed to have the capacity to make a decision, unless it can be established that they lack capacity.
- 10.2 All decisions made on behalf of a person who lacks capacity must be made in that person's best interests. In the absence of a valid ADRT, DNACPR order, decision

from a Court Appointed Deputy (CAD) or Lasting Power of Attorney (LPA), the person's best interests will be served by performing CPR, in an emergency.

- 10.3 If a decision relating to resuscitation is to be made, a 'decision-specific' assessment of the person's capacity must be made specifically relating to the DNACPR decision. Please refer to the Mental Capacity Act Policy and chapter 4 of the MCA Code of Practice for detailed information around assessing capacity. Assessments of Capacity should be clearly recorded on the Trust's Mental Capacity Assessment Form 1.
- 10.4 If the patient has an LPA in place, or a CAD, authorised to make decisions in respect of CPR, then the decision of the LPA/CAD should be respected
- 10.5 If the assessment shows that the person lacks capacity to make a decision relating to DNACPR, the decision must be made on their behalf using the best interest guidelines. These are set out in the MCA Code of Practice. In some cases not all of these factors will be relevant, and in others additional factors may need to be considered. Please refer to the Mental Capacity Act Policy and chapter 5 of the MCA Code of Practice for further guidance when determining best interest decisions. Best interest decisions should be made with involvement from the multidisciplinary team where possible and clearly documented, including as much information as possible on the Trust's Best Interest Decision Form, Form 3.

10.6 **Lasting Powers of Attorney**

An LPA is someone nominated by the patient to make decisions about health and welfare when he or she had capacity. For an LPA to be valid, it must be in a prescribed form, registered with the Court of Protection. For the LPA to be able to make decisions relating to CPR the patient must lack capacity and must have given authority under the LPA to give or refuse consent to life-sustaining treatment on their behalf. The LPA must act in the patient's best interests at all times.

10.7 **Family and friends**

It is a statutory requirement that family and friends are consulted if a patient lacks capacity and clinicians wish to act in his or her best interests. Friends or relatives of patients often believe that they will be the decision maker for the patient, however no person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision-making capacity, except where there is a LPA in place.

Clinicians have authority to act in the patient's best interests where consent is unavailable. People close to the patient should be kept informed and may be asked to reflect the patient's views and preferences, but it must be made clear to them that their role is not to make decisions on behalf of the patient. It is helpful for the clinician to ascertain known wishes of the patient, prior to the loss of capacity, from family and friends whilst making a best interest decision. Details of discussions and those involved should be recorded on the MCA form and within the patient's records.

11.0 CHILDREN AND YOUNG PEOPLE

- 11.1 A child is someone under the age of 18. The MCA applies to anyone aged 16 and over but they cannot make an ADRT or give an LPA until the age of 18.
- 11.2 As a general rule, the wishes of a ‘Gillick competent’ child, who has sufficient understanding and intelligence to understand what is proposed by way of treatment, should be respected. Decisions relating to resuscitation should be made in full consultation between all relevant professionals and the parents. Staff should not rely solely on the wishes or directions of parents. Parents or anyone with parental responsibility must, however, be consulted as to whether the proposed contents of the Personal Resuscitation Plan (PRP) seem appropriate. Where feasible, the child’s wishes should be obtained. (See http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html for basic information on ‘Gillick competence’)
- 11.3 It will normally be the case that the overall responsibility for drafting and reviewing PRPs rests with the Consultant Paediatrician. S/he should draft and review the PRP in consultation with the relevant nursing teams. The PRP must be recorded in the documentation.
- 11.4 If agreement cannot be reached as to whether CPR or other emergency treatment would be in the best interests of the child, e.g. there is an issue between staff and parents about the application of a PRP, a Court declaration should be sought.
- 11.5 The consultant and nursing team must ensure the plan is communicated to all those involved in the child’s care. It must be ensured that schools where children subject to a PRP attend are fully aware of the PRP, are issued with copies and updates as necessary and that there is full and effective communication between all medical and nursing teams working with that particular child and school.
- 11.6 If a child is incompetent, in the absence of a PRP, staff should provide emergency treatment in child’s best interests, using the same principles that apply to adults.
- 11.7 In an emergency situation, any doubt should be resolved in favour of preserving life.

12.0 COMMUNICATION

- 12.1 If the individual has capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family and friends must be respected. Where individual’s lack capacity and their views on involving family and friends are unknown, health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individuals ‘care and is not contrary to their interests’
- 12.2 Effective communication concerning the individual’s resuscitation status will occur between all members of the multidisciplinary healthcare team involved and across the range of healthcare settings

- 12.3 For in-patients a DNACPR decision should be recorded on the handover sheet and resuscitation status should be verbally handed over at the start of each shift
- 12.4 Any additional measures used to communicate resuscitation status must be accurate and used consistently in the clinical area e.g. red dots on whiteboard, lists of patient resuscitation status.

13.0 TRANSFERRING PATIENTS

- 13.1 When transferring a patient, the original DNACPR form should be seen by the ambulance crew and remain filed in the accompanying medical notes or patient care record. Photocopied DNACPR forms or Personal Resuscitation Plan (PRP) should not be sent unless they are acceptable to the transferring ambulance service and receiving healthcare provider. They may accept a copy which they should sign to say they have seen the original.
- 13.2 **Internal transfers and all accompanied visits off Trust premises**
If the patient is transferred to another ward or hospital, the DNACPR order will remain in place until reviewed by the new consultant.
- 13.3 If a patient is taken off Trust premises and accompanied by a Trust member of staff, the original DNACPR order or PRP must travel with the patient and be adhered to if necessary.
- 13.4 **Transfers into EPUT Services**
Where a patient is transferred into an EPUT service with a current and applicable East of England unified form of DNACPR, this decision will be upheld until it is reviewed by the receiving consultant.
- 13.5 Where a patient is transferred with an existing DNACPR form, this should be checked for accuracy and completeness (See appendix 1), particularly with regard to discussion with relatives. If this discussion has not taken place, then arrangements should be made to address this as soon as possible with the patient's consent or as part of a best interest decision if they lack capacity.
- 13.6 **Transfers out of EPUT Services**
When a patient is transferred out of EPUT services with a DNACPR order, the original order must accompany them and should be reviewed by the GP or consultant taking charge of the patient.

14.0 REFERENCES

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2. **Department of Health** (2005) *Mental Capacity Act 2005*
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9. **Office of the Public Guardian** (2013) Mental Capacity Act: Code of Practice <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>
10. **Resuscitation Council (UK)** (2016) DNACPR <https://www.resus.org.uk/dnacpr/>
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