POLICY FOR MAKING “DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION” (DNACPR) DECISIONS

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To support inclusive access of this policy (guideline etc), it has been left-aligned and is available in alternative formats. To obtain a copy of the policy in large print, audio, Braille (or other format) please contact the Communications Team, email communications@derbyshirecountypct.nhs.uk or by Tel: 01773 525099
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POLICY FOR MAKING “DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION” (DNACPR) DECISIONS

1. FULL DETAIL OF POLICY

Although Cardiopulmonary Resuscitation (CPR) can be attempted on any person prior to death, there comes a time for some people when it is not in their best interests to do so. It may then be appropriate to consider making a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision to enable the person to die with dignity.

1.1 Responsibility for Decision Making

Many patients have a growing expectation to either make their own decisions or be included in the discussions about their treatment and care.

The overall clinical responsibility (on behalf of Derbyshire Community Health Services (DCHS)) for a DNACPR decision rests with the most senior clinician in charge of the patient’s care, supported by other professionals who are looking after the patient. The most senior clinician in charge of the patient's care will usually be the medical practitioner in charge of the case e.g. the General Practitioner (GP), Consultant, Staff Grade, Specialty, or Associate Specialist Doctor.

Whilst overall responsibility rests with the most senior clinician it is accepted that at times the most senior clinician may not be available to document the DNACPR. At such times, which are expected to be the exception, a senior clinician (see 1.2) may, after discussion with other appropriate team members, feel it is within their competency to document a DNACPR decision. The organisation would support such a decision if it is justifiable, documented appropriately and reviewed by the most senior clinician as soon as possible.

For health and social care professionals it is important to emphasise that only those with competency should be involved in the more serious components of Advance Care Planning (ACP) about medical treatment. End of Life Decision Making as part of ACP is not a tick box exercise to be undertaken by professionals without careful consideration and support for those involved.

If a patient wants to register their advance decisions in the absence of the most senior clinician two members of staff, including the member of staff who is in charge of the patient's care at that time, may witness a patient's verbal request not to be resuscitated and record it in the patients record until a DNACPR form can be completed.

All staff involved in ACP should facilitate and encourage patient involvement wherever possible by encouraging discussion and making information available.

1.2 Who can make the DNACPR decision?

The Patient
The Patient can make their own decision in advance to refuse CPR see section 11.3

The Patient’s legal proxy
The Patient’s legal proxy e.g. a registered Lasting Power of Attorney (Health and Welfare) with specific delegated authority given to them by the person when they had capacity.

**Senior Clinicians**

The Most Senior Clinician in charge of the case e.g. Medical Practitioners - GP, Consultant, Staff Grade / Specialty / Associate Specialist Doctor

Supported by and working in partnership with other Senior Clinicians who are caring for the patient e.g.
- Nursing - Consultant; Matron; Advanced Nurse Practitioner; Community Matron or Specialist Nurse (e.g. Heart Failure or District Nurse) Senior Staff Nurse
- Therapist – Consultant or Senior Practitioner
- Approved / Recognised other senior clinician e.g. East Midlands Ambulance Service

### 1.2.1 DNACPR decisions made by other professionals in different organisations

A DNACPR decision made in another hospital prior to admission to a Community Hospital or a Community Service must always be reviewed at the earliest possible opportunity. Where there is a DNACPR in place and after consideration it appears to be valid and still applicable it provides very good evidence to allow its continuation until the next review is undertaken as soon as practicable and clinically appropriate. This should be within 24 hours where the chance of a cardio pulmonary arrest is high.

### 1.2.2 Prior to Admission to the Service

On referral key clinical information must be discussed and documented including DNACPR / End of Life Decisions (See [DCHS Admissions Policy](#)). During this process it is essential to understand the basis and status of any such decisions.

### 1.2.3 At Admission to the Service

Where there is no DNACPR in place and the patient is stable and not expected to deteriorate, the review of the resuscitation status should be completed as soon as practicable and clinically appropriate. For patients admitted onto the community nursing service the review of the resuscitation status is required only if clinically indicated (Appendix 3).

Where there is a DNACPR in place and after consideration it appears to be valid and still applicable it provides very good evidence to allow its continuation until the next review is undertaken as soon as practicable and clinically appropriate.

### 1.2.4 At Discharge

Any DNACPR decision (or other relevant End of Life Decision) that has been made and remains valid after discharge should be discussed with the professional / team / practice / organisation receiving the patient and providing the ongoing care.

The importance of teamwork and good communication cannot be over-emphasised and opportunities should be afforded regularly to discuss issues relating to DNACPR orders at multidisciplinary team meetings.
1.3 Adult Patients Who Have Mental Capacity

Each patient will be treated as an individual and their rights and wishes currently and previously expressed will be central to any decision making process regarding resuscitation.

- Decisions about whether to attempt to resuscitate a particular patient will ideally be made in advance as part of the overall care planning with the patient and this will be discussed along with other aspects of future treatment and care.

- All patients will be given all appropriate help and support to enable them to make their own decisions or to maximize their participation in any decision making process, but patients will not be forced to discuss their own views and wishes regarding resuscitation.

- When a patient has a legally valid advance decision to refuse CPR in place which applies to the prevailing clinical circumstances, then CPR must not be commenced. This advance decision over rides any other decision relating to CPR. This decision should not effect the provision of other treatment or care in any adverse manner.

- In some circumstances discussion with the patient may be considered inappropriate and the decision must then be made by a senior clinician (See 1.2) e.g.
  
  i. If the patient indicates that they do not wish to discuss resuscitation. The patient should understand that there are further opportunities to talk about attempting CPR but they should not be forced to discuss the issue if they do not want to.
  
  ii. If the patient lacks mental capacity.

1.4 Adults Who Lack Capacity

Everyone working with and/or caring for an adult who may lack capacity to make decisions must comply with the Mental Capacity Act 2005, and the Code of Practice 2007. Please refer to the Primary Care Trust (PCT) policy on the Mental Capacity Act.

No person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision making capacity unless they have been given this authority (e.g. Lasting Power of Attorney) to make specific decisions on health matters. A Lasting Power of Attorney who has been given the responsibility for financial matters alone cannot take this role although it is recognised that health and welfare related decisions have a financial impact.

A senior clinician has the authority to act in the best interest of a patient where consent is unavailable and where an urgent decision is necessary preventing a more formal and wider best interest’s assessment.

Unless it is contrary to the patient’s wishes, patients nearest relatives/carers will be kept informed about the patient’s health and their views will be taken into consideration. A senior clinician or a member of the multidisciplinary team must perform a Best Interests Assessment (Appendix, 1) in situations where decisions relate to CPR or other possible
treatments for serious medical conditions and when there is appropriate time. This is to try and ascertain what the patients wishes may have been when they had capacity.

Consider including the following people:

- Those close to the patient - family and carers / friends
- Those already currently or recently involved in the patient’s care e.g. GP, Consultant, Key Worker
- Those nominated by the person either informally or formally e.g. Lasting Power of Attorney
- Those nominated by the system e.g. Independent Mental Capacity Advocate or Court Appointed Deputy

In situations where urgent decisions are necessary and there is no reasonable opportunity for wider discussion, it is then the responsibility of a senior clinician to make that decision. Documentation of this decision and subsequent actions must be made in a contemporaneous and appropriate manner.

Relatives cannot demand treatment which the healthcare team judges to be inappropriate but every effort will be made to accommodate their wishes and preferences.

1.5 Children and Young People

It is widely recognised that medical decisions relating to children and young people should ideally be taken in a supportive partnership involving patients, their families and the health care team.

The European Court of Human Rights has taken the view that parents have the right to be involved in important decisions concerning their children.

Where a competent young person refuses treatment, the harm caused by violating their choice must be balanced against the harm caused by failing to treat.

Decisions relating to resuscitation of children and young adults may be very complex and may need specialist legal advice.

1.6 Information Booklet

To aid communications by explaining CPR, a patient information booklet “Decisions About Cardiopulmonary Resuscitation (CPR)” is available to all patients, their relatives, friends and carers. This booklet is based on the British Medical Association template (Appendix 2).

1.7 When is it Appropriate to Consider a DNACPR Order?

A decision making framework has been added to the policy which sets out when it is appropriate to consider a DNACPR order (Appendix 3). The framework has been developed by NHS East Midlands based on information from the BMA, RCN and Resuscitation Council (UK).
The patient’s Consultant, Doctor, or other members of the multidisciplinary team, may undertake the preliminary discussion leading to the application of a DNACPR order.

A clinician’s decision not to perform CPR will only be made after appropriate consultation and consideration of all aspects of a patient’s condition, and if possible as part of a Best Interests Assessment (Appendix 1). These include:

i. the patient’s human rights, including the right to life and the right to be free from degrading treatment;

ii. the patient’s known or ascertainable wishes;

iii. the likely clinical outcome, including likelihood of successfully restarting the patient’s heart and breathing, and the overall benefit achieved from successful resuscitation.

If a patient refuses a DNACPR order contrary to clinical judgment, then the order will not be written. It is the responsibility of the most senior clinician to decide whether a decision has to be made quickly based on the clinical assessment and probability of a cardiopulmonary arrest or if it is relevant to postpone the decision to allow the patient to reflect and reconsider. Refer to section 1.13 (Disagreement).

1.8 Recording Decisions

Any decision relating to CPR must be clearly documented, signed and dated, in the patient’s records by a senior clinician. In all cases the patient’s medical record must document:

- the reasoning behind the DNACPR decision;
- it must be dated and signed, including designation of the person signing;
- if any change in status has been made, especially if the DNACPR status has been reversed.

Once the decision has been documented by a senior clinician it is their responsibility to inform the nurse in charge of the decision.

Only after the decision has been recorded in the patient’s medical records on the approved DNACPR form (Appendix 4) will this decision be reflected in other records such as the multidisciplinary notes.

Patients cared for in the community should have the DNACPR status clearly documented in the appropriate documentation, e.g. patient held records, the Unified End of Life Documentation.

1.9 Reviewing the DNACPR Status

The resuscitation status of all patients should be reviewed as part of the clinical management plan. The frequency of reviews should be guided by the on-going clinical condition of the patient as this can change depending on the nature of their problem. On admission to hospital for patients where the chance of a cardiopulmonary arrest is high, review within 24 hours should be accomplished. For patients already admitted to a service or case load, reasonable practice would include a weekly review as part of the
multidisciplinary assessment. If the prevailing situation is long standing, particularly if the patient is being cared for on a community case load, then the frequency of reviews should reflect this but the date of the next planned review should be recorded. Review of the DNACPR status should be part of the on-going holistic care of the patient.

1.10 Communication DNACPR and End of Life Decisions

Any significant decision such as DNACPR must be communicated to all appropriate members of the immediate care team. It is relevant to consider a number of other people:

- The person (there must be good reason not to do this)
- The family and carers (again it is important that they are informed unless the patient requests otherwise)
- key worker (health and social services)
- the person nominated as a Lasting Power of Attorney for Health and Welfare or legal decision maker for a patient lacking mental capacity
- the patient’s GP and Consultant (if a known / current patient)
- other agencies that might be involved in the treatment and care of the patient e.g. Out of Hours Medical Services (Appendix 7), East Midlands Ambulance Service (EMAS) (Appendix 5).

It is possible in some circumstances to exclude some of these people from such communications, e.g. where the patient has stipulated.

All staff have a duty to comply with the confidentiality code as part of good information governance.

1.11 Communication at Discharge

The discharge process can relate to a number of circumstances e.g. being discharged from a service based on a Community Hospital site to home, being readmitted to an “acute” hospital or being discharged from a case load. There is a professional duty of care to inform colleagues of important information that relates to the treatment and care of patients at discharge. This must support the continuity of care but not breach standards of patient confidentiality or professional conduct.

- When a patient with an existing DNACPR order is to be transported by EMAS nursing staff must ensure this status is recorded on the Transport Form and inform EMAS using the EMAS Registration of End of Life Care decision (Appendix 5). End of Life Decisions, including DNACPR, can be registered with EMAS using appendix 5. If a new DNACPR decision has been made and remains valid this registration must be made.

- When a patient with an existing DNACPR order is transported by the Patient Transport Team, nursing staff must ensure that this status is recorded on the Patient Transport Service Do Not Attempt Resuscitation Form (Appendix 6).

- When a home assessment visit has been agreed by the multidisciplinary team and the patient has a DNACPR status, this status must be reviewed and documented prior to the home assessment taking place. If the DNACPR status remains unchanged this must be communicated to all agencies/members of the multidisciplinary team who are attending the home assessment as well as transport providers (EMAS, Patient Transport Services). The action to be taken in the event of
the patient having a cardiopulmonary arrest on a home assessment visit must be documented in the patient’s medical and multidisciplinary notes. Family members who are participating in the home assessment visit should also be made aware of the patient’s DNACPR status, where this is relevant and appropriate. Local procedures should be developed so that all staff participating in home assessments are clear as to the action they should be take.

- The patient’s GP should be informed of the DNACPR decision and this is especially important if the patient is to be taken on a home assessment visit before discharge home.

- DNACPR status must be included in the discharge letter requesting the GP to review as soon as appropriate. Where there is a high chance the patient might die soon after discharge the GP should be contacted before discharge occurs. It would also be appropriate to inform the out of service, Derbyshire Health United (DHU) using the DHU Special Patient Note Form (Appendix 7). Other communications to primary care teams and emergency care providers (EMAS) should be timely and meet the same standard as described in this document.

- DNACPR status must be included in referrals to day services and community services, e.g. community nursing, intermediate care, so they can liaise with the patient’s GP regarding a review. This information must remain confidential and cannot be used to adversely discriminate against the patient in any form.

1.12 Resuscitation Status in an Emergency

Where no explicit advance decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient suffering a cardiopulmonary arrest, and the expressed wishes of the patient are unknown and cannot be ascertained, there should be a presumption that the healthcare professional will make all reasonable efforts to attempt to resuscitate the patient. This does not apply if:

- There are signs of irrefutable death e.g. decapitation, rigor mortis, dependent lividity, no bystander for cardio-pulmonary resuscitation for 20 minutes following collapse.
- A valid and applicable advance decision to refuse CPR exists.
- If professional judgement suggests the patient is clearly in the last stage of a terminal illness and should be allowed a natural death.

1.13 In the Event of a Clinician finding a person dead

In the event of a clinician finding a person apparently dead and there is no known DNACPR decision or advance decision to refuse CPR, the clinician must rapidly assess the case as to whether it is appropriate to commence CPR. Consideration of the following will help to form a decision, but it must be stressed that professional judgement that can be justified and later documented must be exercised:

- what is the likely expected outcome of undertaking CPR?
- is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading if futile?
• providing the clinician has demonstrated a rational process in decision-making, DCHS will support the member of staff if this decision is challenged.

BMA / RCN / RC (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

• where the individual’s condition indicates that effective CPR is unlikely to be successful
• when CPR is likely to be followed by a length and quality of life not acceptable to the individual
• where CPR is not in accord with the recorded, sustained wishes of the individual who is deemed mentally competent or who has a valid and applicable Advance Decision to Refuse Treatment.

No professional will be compelled to initiate any treatment including resuscitation which is not ethical and clinically justified. This includes the futile act of resuscitating a person who has signs of irrefutable death whether expected or not.

N.B.
In certain conditions a patient may appear dead if not thoroughly examined:

• Following prolonged submersion in cold water
• Following ingestion of alcohol or drugs
• When hypoglycaemic, or in a coma

They may recover completely, if treated appropriately. It should be remembered that hypothermia protects against hypoxic neurological damage, and that children under the age of 5 are more resilient to hypoxic brain injury, and therefore resuscitation should be continued in these circumstances until normal body temperature is reached, even if the patient appears to be dead.

1.14 Disagreement

Where a clinical decision is challenged and agreement cannot be reached at a local service level, this should be brought to the attention of the Medical Director who will attempt to secure a resolution, or after discussion with the senior service manager, may seek legal advice from the PCT solicitor. If the disagreement occurs out of hours staff should contact the operational manager on call who will escalate to the Director on call should this become necessary.

1.15 Promoting Equality and Eliminating Discrimination

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the patient’s age, disability, or on a professional’s subjective view of a patient’s quality of life.

In establishing the patient’s wishes in relation to CPR, it is the responsibility of the relevant healthcare professional to recognise that some patients and their carers/relatives (particularly individuals with speech/hearing impairment, learning disability or other
permanent or temporary cognitive impairment or patients for whom English is not their first language) may need staff to make relevant adjustments and/or give additional time/effort to ensure that appropriate communication and assessment of the patient’s wishes can take place. This responsibility will entail taking such practical steps as are necessary to meet the individual’s needs as far as possible.

The implementation of the policy and compliance with its decision making framework provides staff with the opportunity to promote inclusive equitable treatment of all patients and groups in decisions relating to resuscitation.

1.16 Training

DCHS will provide training sessions on the DNACPR process as required by service demand. The need for training must be highlighted within the individual practitioner's Practice Development Review (PDR) and the line manager must inform the Clinical Education Department of the service need for training to be provided within the organisation.

DCHS provides training for Mental Capacity Assessment which is a mandatory requirement for all staff to attend as per DCHS Essential Training Matrix. It is the line manager’s responsibility to ensure that their staff have undertaken the training.

2. REFERENCES AND ASSOCIATED DOCUMENTATION


- PCT Mental Capacity Act Policy (2007)

3. APPENDICES

Appendix 1  Best Interest Checklist
Appendix 2  Patient Information Leaflet - Decisions About Cardiopulmonary Resuscitation (CPR)
Appendix 3  Making a Do Not Attempt Cardio-Pulmonary Resuscitation Order (DNACPR) Decision Framework
Appendix 4  DCHS - Do not Attempt Cardiopulmonary Resuscitation
Appendix 5  EMAS – Registration of End of Life Care Decision
Appendix 6  Patient Transport Service - Do Not Attempt Resuscitation Form
Appendix 7  DHU Special Patient Note Form
APPENDIX 1  BEST INTEREST CHECKLIST

A person trying to work out the best interests of a person who lacks capacity to make a particular decision should:

- Encourage participation

- Do what ever is possible to permit and encourage the person to take part, or to improve their ability to take part in making the decision.

- Identify all relevant circumstances

- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision to acting for themselves.

- Try to find out the views of the person who lacks capacity, including:
  - The person’s past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
  - Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
  - Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves

- Avoid discrimination;
  - Do not make assumptions about someone’s best interests simply on the basis of the person’s age, race, gender, sexual orientation, religion or beliefs, caring responsibilities, appearance, or behaviour.

- Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

- If the decision concerns life-sustaining treatment do not be motivated in any way by a desire to bring about the person’s death. Assumptions should not be made about the person’s quality of life.

- Consult others if it is practical and appropriate to do so, consult other people for their views about the person’s best interests and to see if they have any information about the person’s wishes and feelings, beliefs and values. In particular, try to consult:
  - Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
  - Anyone engaged in caring for the person
  - Close relatives, friends or others who take an interest in the person’s welfare
  - Any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
  - Any deputy appointed by the Court of Protection to make decisions for the person

- For decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, and Independent
Mental Capacity Advocate (IMCA) must be consulted. (See Chapter 10 for more information about IMCAs).

- When consulting, remember that the person who lacks the capacity to make the decision or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone.

- Where family members have been consulted in the decision making process and there is a dispute with in the family regarding the patient/client's best interests then this should be resolved as soon as possible by ensuring all people concerned have the necessary information to make the decision. If this fails to resolve the situation then mediation should be considered, before an application to the court of protection (see MCA Code of Practice section 15)

- Avoid restricting the person’s rights - identify other options that may be less restrictive of the person’s rights

- Take all of this into account

- Weigh up all of these factors in order to work out what is in the person’s best interests.
Decisions about Cardiopulmonary Resuscitation (CPR)

This leaflet explains what cardiopulmonary resuscitation (CPR) is all about.

The leaflet helps you and your family consider the issues involved and how decisions about CPR are made.

It is a general leaflet for all patients, their relatives and carers, so it may not answer all your questions but it should help you think about the issues. If you have any questions please ask one of the health professionals (doctors, nurses and others) caring for you.

Derbyshire Community Health Services is responsible for providing NHS Services in the Derbyshire County area and is hosted by Derbyshire County Primary Care Trust.
What is Cardiopulmonary Resuscitation (CPR)?

Cardiopulmonary arrest means that a person's heart and breathing stop. When this happens it is sometimes possible to try to restart their heart and breathing with emergency treatment called CPR.

CPR may involve:

- Repeatedly pressing down very firmly on the chest
- Using electric shocks from a defibrillator to attempt to restart the heart
- Breathing into the lungs by use of a mask or inserting a tube into the back of the mouth and inflating the lungs with oxygen.

Is CPR tried on everybody whose heart and breathing stop?

In an emergency, yes, if there is a chance it will work. When the heart and breathing stop unexpectedly, e.g. if a person has a serious injury or heart attack, the healthcare team will try to revive the patient.

When might CPR not be carried out?

If a person's heart and breathing stop working as part of the natural and expected process of dying. If people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them each time their heart and breathing stop. This is particularly true when patients have other things wrong with them that mean they do not have much longer to live. In these cases, restarting their heart and breathing may do more harm than good by prolonging the pain or suffering of someone who is soon to die naturally.

Do people get back to normal afterwards?

Each person is different. A few patients make a full recovery. Some recover but have health problems and, unfortunately some attempts at CPR do not restart their heart and breathing despite
the best efforts of everyone concerned. It depends on why their heart and breathing stopped working and the patient's general health. It also depends on how quickly their heart and breathing can be restarted.

Patients who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some patient's never get back the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some have brain damage or go into a coma. Patient's with many medical problems are less likely to make a full recovery. The techniques used to restart the heart and breathing sometimes cause side effects, for example bruising, fractured ribs and punctured lungs.

Am I likely to have a cardiopulmonary arrest?

Your healthcare professionals are the best people to discuss the likelihood of you having a cardiopulmonary arrest. Even when people have the same symptoms, they do not necessarily have the same disease and people respond differently to illness. Somebody from the healthcare team caring for you, probably the doctor in charge, will talk to you about:

- Your illness
- What you can expect to happen, and
- What can be done to help you.

What is the chance of CPR reviving me?

The chance of CPR reviving you will depend on:

- Why your heart and breathing have stopped
- Any illnesses or medical problems you have (or have had in the past), and
- The overall condition of your health.
You can talk to your healthcare team, about all of these things. Statistics show that on average fewer than four out of ten patients survive a resuscitation attempt, and on average fewer than two out of ten patients who have a cardiac arrest survive long enough to leave hospital. It is important to remember though that these only give a general picture and not a definite picture of what you can expect. Everyone is different and the healthcare team will explain what CPR could do for you.

**Does it matter how old I am or that I have a disability?**

No. What is important is:

- Your state of health
- Your wishes and
- The likelihood of the healthcare team being able to resuscitate you.

Your age alone does not affect the decision, nor does the fact that you have a disability.

**Will I be asked whether I want CPR?**

You and the healthcare professional in charge of your care will decide whether CPR should be attempted if you have a cardiopulmonary arrest. The healthcare team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy. Sometimes, however, restarting people’s heart and breathing leaves them with a severe disability or prolongs suffering. Prolonging life in these circumstances is not always beneficial. Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in these discussions.
What if I don't want to decide?

You don't have to talk about CPR if you don't want to, or you can put the discussion off if you feel you are being asked to decide too much too quickly. Your family, close friends and carers might be able to help you make a decision you are comfortable with, otherwise the doctor in charge of your care will decide, taking into account your wishes.

If you are under 18 your parents can decide for you.

What if we haven't decided and I have a cardiopulmonary arrest?

In this situation the doctor in charge of your care will make a decision about what is right for you. Your family and friends are not allowed to decide for you but it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be asked about your care, you should let the healthcare team know.

I know that I don't want anyone to try to resuscitate me. How can I make sure they don't?

If you don't want CPR you can refuse it and the healthcare team must follow your wishes. You can make a Living Will (also called an 'advance directive') to put your wishes in writing. If you have a Living Will you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked. Also make sure that your Living Will is updated regularly.
What would happen if I was not able to make a decision?

If you were not able to make a decision the healthcare team who were caring for you would decide what to do. If you had previously made a decision and that decision still applied then the healthcare team would respect that. If you had not made a decision the healthcare team would carry out a best interest assessment to try to find out what your wishes might have been.

If it is decided CPR won't be attempted, what then?

The healthcare team will continue to give you the best possible care. The doctor in charge of your care will make sure that you, the healthcare team, together with friends and family that you want involved in the decision, know and understand the decision, unless you don't want to talk about it. There will be a note in your health records that you are "not for cardiopulmonary resuscitation". This is sometimes called a "do not attempt cardio pulmonary resuscitation" order or DNACPR order.

What about other treatment?

A DNACPR order is about CPR only and you will receive all the other treatment you need.

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

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there were any real possibility of it working successfully and helping to bring you back to good health. If there is doubt whether CPR might work for you the healthcare team will arrange a second medical opinion if you would like one. If CPR might restart your heart and breathing but is likely to leave you severely ill or disabled, your opinion about whether these chances are worth taking is very important. The healthcare team must listen to your opinions and to the people close to you, if you want them involved in the discussion. In most
cases doctors and their patients agree about treatment where there has been good communication.

**What if my situation changes?**

The healthcare team will regularly review decisions about CPR particularly if your wishes or condition change.

**What if I change my mind?**

You can change your mind at any time and talk to any of the healthcare team caring for you.

**Can I see what is written about me?**

Yes, you can see what is written about you. You can ask the healthcare team to help you see your healthcare records and, if there is anything in them that you do not understand, they will explain it to you. You also have a legal right to see and have copies of your records. You will need to complete an application form and the Primary Care Trust will advise if a small charge will be made.

**Who else can I talk to about this?**

- Counsellors
- Religious leaders
- Independent advocacy services
- Patient Advice and Liaison Services (PALS)

If you feel you have not had the chance to have a proper discussion with the healthcare team or you are not happy with the discussions you have had, please contact the Matron who can help you or the people close to you and deal with your suggestions and concerns.
Acknowledgement and thanks to the BMA for being given permission to use the template.

www.BMA.org.uk

Patient Advice and Liaison Service (PALS)
If you are a relative or carer and would like to get help on the spot. PALS provides a confidential advice and support service that will help you sort out any concerns you may have about the care provided by the NHS, and guide you through the different services available.

Contact PALS:
NHS Derbyshire County
0800 783 7279

Are we accessible to you? This publication is available on request in other formats (for example, large print, easy read, Braille or audio version) and languages. For free translation and/or other format please call 01773 525099 extension 5587, or email us communications@derbyshirecountypct.nhs.uk

For further information please speak to one of the health care team who is caring for you.

To be published as an A5 booklet
APPENDIX 3  MAKING A DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION ORDER (DNACPR) DECISION FRAMEWORK

Making a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order Framework

Healthcare Professional Completing This DNA-CPR Form

This will vary according to circumstances and local arrangements. In general, this should be the most senior healthcare professional immediately available. Whether in the acute hospital or in the community setting, this will be a senior experienced, doctor or nurse, who has undertaken appropriate training and education in communication and resuscitation decision making, according to the requirements of their employer. This decision should be shared with the Multi-disciplinary Team at the next opportunity.

Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?

- **NO**
- **YES**

If you cannot anticipate what you would write on the death certificate if the patient arrested it may not be possible to make an advance CPR decision. If you cannot anticipate an arrest, consent for, or refusal of, CPR cannot be obtained since any arrest will be unexpected.

Consequences:
- The patient should be given opportunities to receive information or an explanation about any aspect of their treatment. If the individual wishes, this may include information about CPR treatment and its likely success in different circumstances.
- Continue to communicate progress to the patient (and to the family) if the patient agrees. Continue to address the concerns of the patient, partner or family.
- Review regularly to check if circumstances have changed.

In the event of an unexpected arrest: carry out CPR treatment if there is a reasonable possibility of success (if in doubt, start CPR and call for help).

Is there a realistic chance that CPR could be successful?

- **NO**
- **YES**

It is likely that the patient is going to die naturally because of an irreversible condition. Where a decision not to attempt CPR is made on clear medical grounds, it is not appropriate to ask the patient’s wishes about CPR (or those close to the patient where the patient lacks capacity), but careful consideration should be given to whether to inform the patient of the decision.

Consequences:
- Document the fact that CPR treatment will not benefit the patient, e.g. The clinical team is as certain as it can be that CPR treatment cannot benefit the patient in the event of a cardiac or respiratory arrest due to advanced cancer, an DNACPR (Do Not Attempt CPR).
- Continue to communicate progress to the patient (and to the partner or family if the patient agrees or if the patient lacks capacity). This explanation may include information as to why CPR treatment is not an option (as described above) and might include: CPR will not apply in your circumstances and we need to ensure other's know about this decision to ensure your comfort at the end of your life, if that is what you want.
- Continue to elicit the concerns of the patient, partner or family.
- Review regularly to check if circumstances have changed.
- To ensure a comfortable and natural death: effective supportive care should be in place, access with access to specialist palliative care, and with support for the family and partner.
- If a second opinion is requested, this request should be respected, whenever possible.

In the event of the expected death, AND (Allow natural Dying) with effective supportive or palliative care in place.

Does the patient lack capacity?

- **YES**
- **NO**

Are the potential risks and burdens of CPR considered greater than the likely benefits of CPR?

- **YES**
- **NO**

CPR should be attempted

---

NHS

East Midlands

Version 2  Page 23 of 39  October 2010
### DNACPR FORM

**DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR)**

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename(s)</th>
<th>Date of Birth</th>
<th>NHS No</th>
</tr>
</thead>
</table>

**In the event of cardiac respiratory arrest no attempts at Cardio-Pulmonary Resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.**

Please refer to the guidance notes to assist in the completion of this form.

1. **Main clinical problems/diagnosis**

2. **Reasons why CPR would be inappropriate, unsuccessful and not in the patients best interests:**

3. **Is there a valid advance decision to refuse treatment (ADRT) that specifies Cardio-Pulmonary Resuscitation?**
   - YES [ ]
   - NO [ ]

   If YES: Please check and then document if a written copy has been seen, it is valid and is applicable. If the ADRT is valid / applicable and refuses CPR then a DNACPR form is not necessary.

4. **Summarise all relevant communication with patient.**

5. **Summarise communications with patients relatives, friends or representative such as Lasting Power of Attorney:**

6. **Summarise communication with other professionals e.g. key worker, GP, Consultant, specialist nurse or social worker**

7. **Members of multidisciplinary team contributing to this decision:**
8. Senior Healthcare professional making DNACPR order:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td></td>
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<td>Signature</td>
<td>Date</td>
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</table>

9. It may be appropriate for this DNACPR decision to be communicated to East Midlands Ambulance Service to be registered as an End of Life Decision?

Please explain and summarise any actions taken.

**REVIEW DATE**

The first review of this DNACPR order must take place on: ........................................

Any significant decision about patient care should be reviewed in the context of the clinical condition and any changes to their needs. Weekly routine review for in patients is suggested practice where this decision is relevant and appropriate.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name, Designation and Signature of Professional</th>
<th>Outcome (e.g. DNACPR remains valid)</th>
<th>Next Review Date</th>
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</table>

**DNACPR ORDER REVOKED**

Print Name: .............................................  Signature: .............................................

Designation: ............................................  Date: .............................................

When revoked please strike through the front and back of the form with double lines. The decision to revoke must also be recorded in the patient’s records.

It is acknowledged that this form has been developed using the current standards from The Resuscitation Council (UK), BMA and RCN. It complies with the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007.
Notes on completion of DNACPR order

This form should be completed legibly in black ball point ink
All sections MUST be completed. Do not photocopy the form

- The patient's full name, number and date of birth should be written clearly
- The date of writing the order should be entered
- This order will be regarded as “INDEFINITE” unless clearly cancelled
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home

1. **Main clinical problems / diagnosis**
   Summarise all clinical problems relevant to the decision

2. **Reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:**
   Be as specific as possible

3. **Has a valid advance decision (i.e. “living will”) been seen?**
   Answer Yes or NO. Ensure that any directive seen is relevant to the present condition of the patient

4. **Summary of communication with patient**
   State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate

5. **Summary of communication with patient's relatives or friends or patients representative lasting power of attorney**
   If the patient is unable to express their own wishes their relatives or friends may be able to help by indicating what the patient would decide if able to do so.
   If the decision has been discussed with the patient ensure that discussion with others does not breach confidentiality.
   State the names and relationships of relatives or friends with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
   If relatives could not be contacted record what efforts were made to contact them. When patients cannot contribute to decisions relatives cannot make decisions about their resuscitation status but can help such decisions by advising what the patient would have wished if able to decide for themselves.

6. **Members of multidisciplinary team contributing to this decision:**
   State names and positions. Ensure that the DNACPR order has been communicated to all relevant members of the healthcare team.

7. **Summary of communication with other professionals e.g. key worker**
   State the name and designation and agencies involved with patients care

8. **Healthcare professional making this DNACPR order**
   This will vary according to circumstances and local arrangements. In general this should be the most senior professional immediately available.

9. **Endorsement / review by senior healthcare professional:**
   The decision should be discussed with and endorsed by the patient's hospital consultant, general practitioner or other healthcare professionals responsible for the patient at the earliest opportunity.
   A further endorsement may be signed after subsequent review and confirmation that the DNAR order remains appropriate

**CANCELLATION:** If the DNACPR decision is cancelled the form should be crossed through with 2 diagonal lines in black ball point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the order. The reason for cancellation should be documented clearly in the health record.
APPENDIX 5  EMAS REGISTRATION OF EOL CARE DECISION
APPENDIX 6 PATIENT TRANSPORT SERVICE DNACPR FORM

PATIENT TRANSPORT SERVICE
DO NOT ATTEMPT CARDIO PULMONARY RESUSCITATION FORM

In the event of the Patient Transport Service receiving the request to transport a patient in possession of a “Do Not Attempt Cardio-Pulmonary Resuscitation” (DNACPR) order, the information below must be completed in full by the person handing over the patient into the care of the Ambulance Service.

<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Transport Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Address</td>
<td>Convey from</td>
</tr>
<tr>
<td>Job Number</td>
<td>Convey to</td>
</tr>
<tr>
<td>……………………...</td>
<td>………………………………………………………………….</td>
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<td>………………………………………………………………….</td>
<td></td>
</tr>
<tr>
<td>Age ………………</td>
<td>DOB ……/……/…….</td>
</tr>
<tr>
<td>………………………………………………………………….</td>
<td></td>
</tr>
</tbody>
</table>

1. Is the DNACPR order held within the patient's medical notes? YES □ No □
2. Has the DNACPR decision been confirmed in writing within the past seven days? YES □ No □
3. Is the patient aware of the DNACPR order? YES □ No □ Don't Know □
4. Are the patient’s family / next of kin aware of the DNACPR Order? YES □ No □ Don’t Know □

Discharge Arrangements

If, during transportation, the patient suffers a cardio pulmonary arrest, where should the patient be transported to for certification purposes? Note: this cannot be the patient's home address. (Be aware of special arrangements for long distance journeys)

Statement and Signature

I confirm that a valid “Do Not Attempt Cardio-Pulmonary Resuscitation” order is in place in respect of this patient. The person making the DNACPR decision, or their deputy, agrees that the order applies whilst the patient is in the care of the Patient Transport Team, only on this occasion.

It is understood that in the event of cardio pulmonary arrest whilst in the care of the Patient Transport Service, the transport team will abide by that order and will not commence basic or advanced life support skills.

Person responsible for checking that the DNACPR is current for this patient and handing over the patient to the Patient Transport Team

Signed: ……………………………………. Print ……………………………………. Date ……/……/……..

Patient Transport Team:

Signed: ……………………………………. Print ……………………………………. Date ……/……/……..

If, during transfer, cardio respiratory arrest occurs and accompanying relatives are unaware and unhappy at the DNACPR status, resuscitation may be commenced at the team’s discretion.
### APPENDIX 7  DHU SPECIAL PATIENT NOTE FORM

**NHS DIRECT CAS SPECIAL PATIENT NOTE INFORMATION**

Please complete the details below, giving as much information as you feel is necessary. It is the responsibility of the originator to ensure patient consent is obtained.

<table>
<thead>
<tr>
<th>Patient Details:</th>
<th></th>
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<tbody>
<tr>
<td>Surname:</td>
<td>First Name:</td>
</tr>
<tr>
<td>Gender:</td>
<td>Ethnicity:</td>
</tr>
<tr>
<td>Address:</td>
<td>DOB:</td>
</tr>
<tr>
<td>NHS Number:</td>
<td>Postcode:</td>
</tr>
<tr>
<td>Tel No:</td>
<td>Patient's GP &amp; Surgery:</td>
</tr>
</tbody>
</table>

**Diagnosis:**

**Current Medication:**

**Family Contact:**

**Consultant:**

**Care programme co-ordinator**

**Special Patient Information** eg Treatment Plans/Crisis Plans

**Patient Aware:** YES/NO  
**Carers aware:** YES/NO

Consent to share with parties listed in the DHU Data Protection Register: YES/NO  
(If No, state justification for breaching confidentiality)

**Expiry Date (MUST BE SPECIFIED – MAX 12 MONTHS)**

Form completed by: (PLEASE PRINT)

**Address:**

**Contact Tel No:**

**Position:**

**Date:**

On completion of the form please email to [Specialpatientnote.referrals@nhs.net](mailto:Specialpatientnote.referrals@nhs.net)

On receipt at NHS Direct – For immediate attention of team leader/shift supervisor/operations manager. Unless all patient details are provided the information cannot be entered onto NHS CAS.

Version 2 – 30.3.08
4. **Aim**

To clarify the process that takes into account, the complex clinical considerations and ethical issues regarding both the making and the communication of, decisions relating to DNACPR orders.

5. **BACKGROUND**

The primary goal of healthcare is to benefit patients by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If the health of the patient has deteriorated to the point where CPR as a treatment will not be successful and ceases to benefit the patient, or if an adult with capacity has refused CPR treatment a DNACPR order should be made.

This policy has been agreed in accordance with guidance published in “Decisions Relating to Cardiopulmonary Resuscitation – a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing October 2007.

This policy will be made freely available to staff, patients and their relatives and should be seen as a means of de-mystifying the process by which decisions regarding resuscitation are made. Patients will be encouraged to see this information as a routine part of advance care planning.

6. **AREA FOR IMPLEMENTATION**

All DCHS providing care to children and adults.

7. **ORGANISATIONAL ACCOUNTABILITY / RESPONSIBILITIES**

This section sets out who holds organisational accountability and responsibility for the policy.

- The Managing Director holds overall accountability and is responsible for assuring that there are effective systems in place to implement the guidance.

- The Medical Director is the policy sponsor and has overall responsibility for the development of this policy and its implementation. The Medical Director is accountable to the Managing Director of DCHS and holds professional accountability for medical staff and services and is responsible for providing advice on professional and clinical matters relating to the provision of medical care within DCHS.

- The Associate Director of Service Delivery is the lead operational officer for DCHS and is accountable to the Managing Director.

- The Associate Director of Quality and Integrated Governance is accountable for the quality and delivery of care.
Operational Managers have responsibility for managing staff groups, ensuring that staff attend training, risk management, clinical incidents, and competency practice issues once identified. Records of attendance on training will be kept by the Organisation. Patient records will be audited to monitor compliance with the policy.

Professionally Registered Staff including Doctors, Nurses and Allied Health Professionals. Are responsible for ensuring they are familiar with the policy and follow local procedures in relation to implementation of the policy.

All staff are accountable for their own practice and hold individual responsibility to maintain their knowledge and skills in relation to CPR

8. INTENDED USERS

Within this policy where it states “all staff” please note, that it relates to all the staff who are highlighted in the table below. This policy relates to staff in all the clinical services provided by the DCHS and any other staff employed by other providers of clinical services if the patient’s care is led on DCHS sites.

<table>
<thead>
<tr>
<th>DCHS Staff</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance and Information</td>
<td>No</td>
</tr>
<tr>
<td>Quality and Integrated Governance</td>
<td>Yes</td>
</tr>
<tr>
<td>Strategy and Corporate Development</td>
<td>No</td>
</tr>
<tr>
<td>Service Development and Performance</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Delivery and Operational staff</td>
<td>Yes</td>
</tr>
<tr>
<td>Human Resources</td>
<td>No</td>
</tr>
<tr>
<td>Medical Directorate</td>
<td>Yes</td>
</tr>
</tbody>
</table>

9. DEFINITIONS

9.1 Cardio-pulmonary resuscitation (CPR). Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

9.2 Cardiac Arrest is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal gasping respiration. In simple terms, cardiac arrest is the point of death.

9.3 The Mental Capacity Act (2005) (MCA), was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.

9.4 Mental Capacity: An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals that lack capacity will not be able to:

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

9.5 Advance Decision to Refuse Treatment (ADRT). A decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.

9.6 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) refers to not making efforts to restart breathing and / or the heart in cases of respiratory / cardiac arrest. It does not refer to any other interventions / treatment / care such as analgesia, fluid replacement, feeding, antibiotics and basic care etc.

9.7 Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA). The Mental Capacity Act (2005) allows people over the age of 18 years of age, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and welfare - being on their behalf once capacity is lost.

9.8 Independent Mental Capacity Advocate (IMCA). An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them.

9.9 A Court-appointed deputy is appointed by the Court of Protection (Specialist Court for issues relating to people who lack capacity to make specific decisions) to make decisions in the best interests of those who lack capacity.

9.10 Best Interest Assessment This is a process where the benefits and risks are objectively considered of any decision (and related action) on behalf of the person who lacks mental capacity for that specific decision. This assessment and decision must be in the person’s best interests. A Best Interests checklist is available in section 14 of staff guidance in the PCT’s Mental Capacity Act Policy available on the PCT intranet to assist the assessment. It is also included in appendix for reference (Appendix 1).

10. (CLINICAL POLICIES ONLY) INDICATIONS FOR USE

When a decision not to attempt resuscitation is taken by the senior clinician / health professional because:
• the patient’s condition indicates that effective CPR is unlikely to be successful
• if a patient with capacity indicates that they do not want CPR.

11. (CLINICAL POLICIES ONLY) CONTRA-INDICATIONS

When there is an expectation that cardiopulmonary resuscitation is:
• expected to have a reasonable chance of success and the benefits of such an attempt outweigh the risks to the person and where there is no other legally binding and over riding decision.
• where there is reasonable doubt there should always be a presumption to offer CPR until any doubt is resolved.
• other treatment and care that are appropriate will continue to be considered and offered unless there is a valid and applicable advance decision (by either the patient or professional) to refuse a specific treatment in certain circumstances.

12. EQUALITY IMPACT STATEMENT

We welcome feedback on this policy and the way it operates. We are interested to know of any possible or actual adverse impact that this policy may have on any groups in respect of gender or marital status, race, disability, sexual orientation, religion or belief, age, deprivation or other characteristics.

The person responsible for the original equality impact assessment for this policy was the Assistant Director of Quality and Patient Experience and has been reviewed by the Head of Clinical Effectiveness.

This policy has been screened to determine equality relevance for the following equality dimensions – race, gender, disability, age, sexual orientation, religion/belief, transgender/trans-sexual status, and deprivation. The policy is considered to be of high equality relevance for all equality groups. A full impact assessment will be completed by 31\textsuperscript{st} March 2011.

13. MONITORING AND PERFORMANCE MANAGEMENT OF THE POLICY

The Medical Director has overall responsibility for monitoring the content of the policy.

The policy will be reviewed every two years unless changes in clinical practice occur more frequently which require review prior to this and/or monitoring data highlights the need for an earlier review.

Prospective monitoring of the implementation of the policy and related action will be achieved by:

• Auditing of the Clinical Records Documentation
• Resuscitation Audit
• Monthly Mortality Audit
• Monitoring of the equality profile of patients for whom action is taken under this policy.
• Monitoring of any complaints relating to a decision to undertake CPR (or not undertake CPR) on an annual basis, with the review including consideration of both data on the equality profile of the patient(s) involved and the qualitative nature of the complaint(s).
• Audit of training sessions delivered and number of staff attended.

14. SUPPORT AND ADDITIONAL CONTACTS

Contact: Medical Director
         Derbyshire Community Health Services
         Derbyshire County PCT
POLICY FOR MAKING “DO NOT ATTEMPT RESUSCITATION” (DNACPR) DECISION

Ilkeston Community Hospital          0115 9305522 ext 275
For urgent/emergency enquiries      0782 489 5823

Email:  ben.lobo@derbyshirecountypct.nhs.uk

Medical Director PA
Derbyshire Community Health Services
Ilkeston Community Hospital          0115 9305522 ext 275

Email:  melanie.dakin@derbyshirecountypct.nhs.uk
### Equality & Diversity Impact Assessment: Level I Screening

<table>
<thead>
<tr>
<th>Which of the following diversity profiles have high relevance to this policy/procedure/process/practice?</th>
<th>Race</th>
<th>Gender</th>
<th>Disability</th>
<th>Age</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religion/Belief</strong></td>
<td><strong>Transgender/Transsexual</strong></td>
<td>This policy is relevant to all diversity profiles</td>
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</table>

1. **What is the purpose of the item under assessment?**

   The policy identifies the process to follow (taking into account the complex clinical considerations and the ethical issues) regarding the making and communicating of decisions related to do not attempt resuscitation (DNACPR) orders.

2. **What is the background to the item? (e.g. in response to a statutory requirement, development of good practice, organizational review etc.)**

   Department of Health guidance requires all Trusts to have a policy for decisions relating to cardiopulmonary resuscitation. The policy is based on the joint statement from the BMA, Resuscitation Council and RCN published in October 2007.

3. **What potential is there for negative impact on people who are directly affected?**

   Whilst there should be no negative impact on people who are directly affected by this policy, there may be situations where a number of equality factors (for example, mental health difficulty, incapacity, temporary or permanent cognitive impairment) could impair communication and accurate fact-finding and/or the full identification and consideration of the patient’s wishes.

   There is considerable scope for negative impact on people who are directly affected by the policy in circumstances where either staff do not have sufficient understanding of the additional actions that might be required (for some patient groups) to comply with the procedures set out in the policy and/or a patient’s ability to communicate their wishes in relation to resuscitation is impaired (temporarily or permanently).

4. **Is there up to date data on the groups/individuals on whom there may be impact?**

   There is a range of available data (for example, the equality profile of Derbyshire County and patient data). A monthly mortality audit is now in place and a continual audit of CPR events is undertaken. Analysis of these audits could highlight areas where more in-depth analysis against a diversity profile.

   It would also be relevant to monitor complaints relating to decisions on CPR. Consequently, it is recommended that any complaints relating to a decision to undertake CPR (or not undertake CPR) be monitored on an annual basis with the review including consideration of both data on the equality profile of the patient(s) involved and the qualitative nature of the complaint(s).
<table>
<thead>
<tr>
<th>5</th>
<th>Have there been changes to the equalities profile of the above groups/individuals since the collection of the data?</th>
<th>The equality profile of Derbyshire is subject to on-going change. For example, the over 65 age group is set to increase by 46.2% by 2025. It is recommended that the monitoring and review of equality data on the profile of patients for whom action is taken under this policy and any complaints relating to a decision to undertake CPR (or not undertake CPR) be repeated on an annual basis. This will ensure that the Trust monitors any trends and takes appropriate action, as required.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Does the policy etc. influence in a positive way relations between different groups of people? Give brief details</td>
<td>The policy has the scope to positively influence relationships between different groups of people by anticipating circumstances where other decision makers might need to be contacted (or representation arranged) to accurately establish either the existence of a valid DNACPR and/or the patient’s resuscitation status. This will help support the equitable treatment of patients, particularly in circumstances where a patient lacks capacity or needs assistance to be able to effectively communicate their wishes. Proactively anticipating that some patients will require the involvement of other decision makers / representation in order that informed decisions (in the patient's best interests) on their resuscitation status can be reached will: • Contribute to the removal or reduction of barriers between different groups) • Help promote positive relationships with patients and their carers / relatives</td>
</tr>
<tr>
<td>7</td>
<td>Does it promote equality of opportunity? Give brief details.</td>
<td>This policy has significant scope to promote equality of opportunity. Some of the supporting reasons for this are set out in the response to Question 6. The implementation of the policy (and compliance with its decision-making frameworks) provides clinical staff with the opportunity to promote inclusive, equitable treatment of all patient groups in decisions relating to resuscitation.</td>
</tr>
<tr>
<td>8</td>
<td>Does the item either eliminate or contribute to the elimination of unlawful discrimination across all equalities themes? Give brief details.</td>
<td>The policy sets out decision-making frameworks that aims to properly consider each individual’s circumstances and all the available information that could be relevant to the patient’s resuscitation status. The policy gives priority to ensuring that the views and wishes of the patient are ascertained (whilst also recognising that the involvement of other decision makers / representation will be required in some circumstances (for example, where a patient lacks capacity). This has the potential to eliminate discrimination against those who are less able to communicate their wishes and provide their own advocacy.</td>
</tr>
</tbody>
</table>
9. Is there any evidence or are there any concerns about the item having the potential for adverse impact on any group(s) of people? Give details.

See 3 above.

It is also reasonable to anticipate that there is an increased risk for some patients (particularly patients with hearing and/or speech impairment, learning disability or other permanent or temporary cognitive impairment or patients for whom English is not their first language) of experiencing difficulty in communicating their wishes in relation to resuscitation.

Qualitative feedback suggests, however, that in a number of such situations a patient will be more able to communicate their wishes providing that appropriate additional steps are taken. In addition to referring to other decision makers and representatives, practical reasonable adjustments could aid effective communication with the patient as could the use of interpreters.

It is important that relevant clinical staff are able to accurately establish what adjustments would minimise or remove communication barriers as far as is reasonable possible.

10. Actions following previous Impact assessment

- Policy has been left hand aligned
- Policy is in Arial 12 font
- All DCHS policies are now on the internet and available to the public
- DNACPR training is being addressed as part of the End of Life Pathway training
- Mental Capacity act training is mandatory for all DCHS employees
- The paragraph ‘In establishing the patient’s wishes in relation to CPR, it is the responsibility of the relevant healthcare professional to recognise that some patients and their carers/relatives (particularly individuals with speech/hearing impairment, learning disability or other permanent or temporary cognitive impairment or patients for whom English is not their first language) may need staff to make relevant adjustments and/or give additional time/effort to ensure that appropriate communication and assessment of the patient’s wishes can take place. This responsibility will entail taking such practical steps as are necessary to meet the individual’s needs as far as possible’ has been incorporated into the policy as suggested.
- All Patient and Carer information is available in a range of formats (including large print, electronic file, Braille, DVD with sign-language) and other languages on request.
- The PPI readers panel have advised regarding the patient information booklet
- Monthly Mortality Audit is now undertaken and an audits on medical emergencies and resuscitation attempts is undertaken these will need to be developed to take account of the patient profile.
• All documentation referred to in this policy has been reviewed in relation to equality considerations.

| Level 1 Assessment – Signing off date: October 2010 Jenny Mellor Previous EIRA Reference: CLIN/E&D70/08 | No further action  □  Level 2 Assessment required (*please indicate*)  □ √  Full assessment to be undertaken by 31st March 2011 |