DECISIONS RELATING TO CARDIOPULMONARY RESUSCITATION POLICY

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<tr>
<th>Date</th>
<th>Comments</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>Oct 2007</td>
<td>Document reviewed in line with NHSLA Risk management Standards</td>
<td>Michaela Morris</td>
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<tr>
<td>Dec 2010</td>
<td>Review of document and addition of spiritual support statement</td>
<td>Resuscitation Committee</td>
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<tr>
<td>June 2012</td>
<td>Review and amendment of policy in line with new directives from NHS Surrey.</td>
<td>Resuscitation Committee</td>
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<tr>
<td>January 2015</td>
<td>Review and updated new DNACPR form</td>
<td>Resuscitation Committee</td>
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Compiled by: Paul Darling-Wills, Resuscitation Services Manager

Ratified by: Trust Board

Date: October 2012

Date Issued: January 2015

Next review date: December 2017

Target Audience: All staff

Impact Assessment Carried Out by: Paul Darling-Wills, Resuscitation Services Manager

Policy Owner: Paul Darling-Wills, Resuscitation Services Manager
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1. INTRODUCTION

This document sets out the process to be followed when making decisions relating to cardiopulmonary resuscitation in adults only.

Cardiopulmonary resuscitation (CPR) can be attempted on any person when cardiac or pulmonary functions cease. However, because for every person there comes a time when death is inevitable, it is essential to identify patients in which cardiopulmonary arrest is a likely event with an expected poor outcome and therefore attempting CPR is inappropriate. It is also essential to identify those patients that do not wish CPR to be attempted.

All establishments that face decisions about attempting CPR, including hospitals, general practices, residential homes and ambulance services, should have in place a policy regarding resuscitation attempts. NHS Trust Chief Executives are required to ensure that policies are in place that respect patients’ rights, are understood by all relevant staff and accessible to those who need them.

A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision only impacts on whether or not resuscitation procedures should be commenced following cardiac arrest. It does not equate to a ‘do not treat’ decision.

A key decision in the DNACPR process surrounds the likelihood of the patient surviving the cardiac arrest with a reasonable chance of discharge home in a condition no worse than before the cardiac arrest.

2. PURPOSE

This policy will make clear to staff the procedures that should be followed when a patient is identified as benefitting from a DNACPR order. It will also cover admission and discharge of patients with existing DNACPR orders at home or from other institutions (e.g. nursing home or hospice).

3. DEFINITIONS

DNACPR

Do not attempt cardiopulmonary resuscitation: in the event of a patient going into cardiac arrest (unresponsive, absence of normal breathing and no palpable pulse) no cardiopulmonary resuscitation will be attempted (i.e. no chest compressions and ventilation support)
4. DUTIES / RESPONSIBILITIES

EXECUTIVE LEADS - MEDICAL DIRECTOR & CHIEF NURSE

1. Report to the board of directors
2. Provides advice and support to admitting consultants

RESUSCITATION COMMITTEE

1. Effectively monitors reporting process from the resuscitation service

RESUSCITATION SERVICES MANAGER

1. Undertakes annual monitoring of DNACPR documentation reporting to the resuscitation committee.
2. Monitor compliance by review and attendance at priority calls.

ADMITTING CONSULTANTS

1. Leads their team and directs / advises on appropriateness of treatment to include DNACPR orders
2. Adheres to the Ashford and St Peters NHS Foundation Trust DNACPR policy
3. Facilitates the discussion with patients and patients’ representatives and ensures relevant paperwork is completed.
4. Is involved in all new DNACPR decisions and will review the DNACPR paperwork at the next ward round or within 24 hours of the decision.
5. All existing community DNACPR orders must be reviewed on admission to hospital and transferred on to a Trust DNACPR form (if currently on a community red bordered or Lilac form) within 4 hrs of admission. When this is completed by a junior doctor, this must be reviewed by the admitting consultant at the next ward round.
6. Every DNACPR decision must be communicated effectively by the patient’s consultant to all members of their team (including nursing staff) paying particular attention to temporary or locum staff who may be unaware of this policy.
7. The decision should also be communicated to the patient’s GP, matrons of nursing homes, ambulance staff or community health professionals as part of normal transfer or discharge procedures.
8. All patients with a DNACPR order should be reviewed prior to discharge. If appropriate the patient may be discharged with the DNACPR order. Alternatively, the DNACPR order may be cancelled and filed in the patient’s medical record.

REGISTRARS

1. The overall responsibility for a DNAPCR order rests with the admitting consultant. However, a registrar can make the decision and complete all appropriate paperwork following discussion with the consultant (if appropriate). The patient should be reviewed by their admitting consultant at the next ward round or within 24 hours of the decision being made.
2. All patients with an existing community DNACPR order must be reviewed on admission. If this review is undertaken by junior doctor, the registrar must be informed about the patient’s DNACPR status.
3. All patients with an existing Hospital/community DNACPR form (as mentioned in point 2 above) must be transferred onto a Trust DNACPR form within 4 hours of admission by a registrar or above.

DOCTORS IN TRAINING (FOUNDATION YEAR 2 OR ABOVE)

1. If an existing DNAPCR order is in place on admission to hospital, this should be reviewed as soon as possible after arrival and discussed with the Registrar of the admitting team or out of hours, the Registrar on Call.
2. It must be documented in the patient’s medical notes that their DNACPR status has been discussed and reviewed and the appropriate review section on the DNAPCR form completed. A trust DNACPR form must be completed within 4 hrs of admission by the registrar or consultant.
3. DNACPR review MUST NOT be undertaken by Foundation Year 1 doctors.

ON-CALL TEAM

If the patient has been reviewed by their own consultant during the previous 24 hours and no ‘DNACPR Order’ made, but the on-call team believe that a DNACPR order is appropriate and or the patient’s clinical condition has deteriorated, then this patient should be discussed with the on-call consultant or, if more appropriate, with the patient’s own consultant before a DNACPR Order is recorded.

5. GUIDELINES COVERING THE BASIS FOR A DNACPR DECISION

A number of key factors need to be considered when deciding on making a patient “Not for Resuscitation”, these are wide and varied and are often patient specific but key factors include:

- Low likelihood of a successful outcome
- A terminal, life limiting illness where admission to ICU, CCU or other specialist area would be inappropriate post resuscitation (or prior to a resuscitation attempt)
- Significant co-morbidities where admission to ICU, CCU or other specialist area would be inappropriate post resuscitation (or prior to a resuscitation attempt)
- Where the patient’s acute or chronic medical condition indicates that cardiopulmonary resuscitation (CPR) is unlikely to be effective
- Where DNACPR is in accordance with the recorded, sustained wishes of the patient who is mentally competent
- Where DNACPR is in accordance with a valid applicable advanced directive (anticipatory refusal or living will)
- The patient’s human rights, including the right to life and the right to be free from degrading treatment

The following should be avoided as the sole criteria for a DNACPR order:

- Perceived quality of life, as this needs to be assessed from the patient’s perspective
- Age

The basis for the decision should be clearly documented on the DNACPR order. If futility is the considered reason, this should be expanded on to include reasons why CPR would be futile.
Treatment of patients with a DNACPR order

All patients with a DNACPR order should receive full and active treatment unless it is specified otherwise in the medical notes or if on an End of Life care pathway.
In the event of a patient with a DNACPR order deteriorating, a 2222 priority call may be activated as an improvement in patient clinical status and prevention of cardiac arrest may be achievable.

6. PATIENT INVOLVEMENT AND CAPACITY
See Also: “Assessing a Patient’s Mental Capacity to Make Decisions”

INVOLVING THE PATIENT IN DNACPR DECISIONS

Patients that are mentally competent should be involved in all decisions relating to their care, this includes the implementation of a DNACPR order. However, it must be recognised that DNACPR decision making can be difficult for patients. It must be remembered that any discussion will only be instigated when the attending clinician believes that a DNACPR decision is clinically appropriate and therefore the patient’s wishes must be considered in conjunction with the chances of a successful outcome post cardiac arrest.

If the patient’s condition is such that they are unable to be involved in the decision-making process the attending clinicians should discuss the appropriateness of a DNACPR order with the patient’s next-of-kin as to what the patient would want. DNACPR remains a clinical decision and must be based on what is in the patient’s best interest and the likelihood of a successful outcome.

Therefore a DNACPR decision should not be delayed whilst seeking the opinions of the patient’s next-of-kin, as next-of-kin do not have the right to give consent for treatment to be administered or withheld.

MENTAL CAPACITY AND DNACPR DECISION MAKING

The Mental Capacity Act (MCA) 2005 was implemented April and updated in October 2007.

The MCA provides a legal framework for making decisions on behalf of adult patients who lack the capacity to make the decisions for themselves. The Trust’s Patient Consent Policy has further information and guidance checklists for capacity and “best interests” assessments.

The MCA has introduced a number of terms that may affect DNACPR decisions; these are Advanced Decisions and Personal Welfare Attorney.

ADVANCE DECISIONS (AD)
See also: “Advance decision to refuse treatment – guidance for staff” & “Patient Consent”

An ‘Advance Decision’ (AD) is where a person aged 18 or over may set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if the refusal may result in the person’s death and if it is valid and applicable it must be followed. An AD does not need to be in writing, except for decisions relating to life-sustaining treatment, but it is helpful if it is.

If a person has made an AD refusing a particular medical treatment, and that AD is valid and applicable, then the refusal has the same force as when a person with capacity refuses treatment. The ‘best interests’ principle does not apply to AD’s.
PERSONAL WELFARE ATTORNEY (PWA)

People aged 18 and over can formally appoint someone to make decisions about their health, personal welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves.

The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person appointed is known as a Personal Welfare Attorney. The LPA will give the attorney authority to make decisions on their behalf and the PWA will have a duty to act or make decisions in the best interests of the person who has made the LPA. All LPA’s need to be registered with the Public Guardianship Office (PGO) and treating clinicians will be entitled to see and copy of the document which should be ‘stamped’ by the PGO. The PGO keep a register of all LPA’s.

The Trust’s Patient Consent Policy has further information and guidance checklists for Advance Decisions and a Personal Welfare Lasting Power of Attorneys.

HUMAN RIGHTS ACT

Decisions about DNACPR must comply with the Human Rights Act 1998. Provisions particularly relevant to decisions about DNACPR include:

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

PATIENTS AGED 16 AND 17 YEARS OLD

See also: “Advance decision to refuse treatment – guidance for staff” & “Patient Consent”

Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless there is evidence to the contrary. However, if they decide to refuse treatment this may be overturned by someone with parental responsibility for them or by the court. If a patient under the age of 18 years wishes to make a DNACPR decision advice MUST be obtained from the Trust’s Legal Team. In the same way, if a Gillick or Fraser competent child agrees to a DNACPR the Trust’s Legal Team must be informed. The clinician is directed to the hospital Patient Consent Policy.

INFORMING THE PATIENTS NEXT-OF-KIN

Family members remain an important part of the patients care but are not routinely in a position to request or deny a specific course of clinical care unless they have personal welfare LPA. This is a different legal requirement to the more common property and affairs LPA that solely deals with financial matters and therefore confers no decision-making authority for health related aspects of the patients care.

The role of the relative/next-of-kin in DNACPR decisions is solely restricted to expressing what the patient would want. They cannot request or refuse care for a patient. It remains good practice to inform the next of kin about a DNACPR decision at the earliest opportunity but a DNACPR decision should not be delayed whilst waiting to communicate this decision.
7. DOCUMENTATION

Once a DNACPR decision has been made, the red bordered Trust DNACPR form should be completed and placed at the front of the patient’s notes. The person who makes the decision is responsible for ensuring the form is completed fully and put in the patient’s medical notes.

All new DNACPR decisions should be discussed with a consultant and their name should be recorded on the form.

All DNACPR forms should be reviewed and signed by the consultant at the next ward round or within 24 hours of the form being completed.

All entries in medical and nursing notes must be dated, signed and the name of the doctor/nurse making the entry printed and legible.

A review date is not always required on the DNACPR form as each subsequent medical review of the patient will prompt a discussion as to the appropriateness of the outstanding decision.

A review date can be added if it is felt to be clinically appropriate.

A review must always be made if the patient’s clinical condition changes.

NURSING NOTES

A record of the patient’s DNACPR status should be made in the patient’s nursing notes and on RealTime. This decision must be handed over daily by nursing staff, in particular, ensuring that bank and agency staff are aware of the decision.

DISCHARGE

On discharge, a decision regarding the DNACPR order is required. In a number of patient’s, clinical improvement may be sufficient to allow the discharging clinician to rescind a previously documented DNACPR decision. However, the discharging clinician must ensure that it is within the patients expressed wishes that a DNACPR decision is rescinded.

For many patients the underlying condition may be such that any future resuscitation attempt remains inappropriate. This is particularly important for patients entering ‘end of life care’.

On discharge the existence of an agreed DNACPR order must be shared (if appropriate) with:

- Patients GP (as part of the discharge letter)
- Hospices
- Nursing homes
- Community hospitals
- Ambulance / Transport Service responsible for discharge transfer

The original DNACPR form should be sent with the patient when they are discharged to a Hospice, nursing home or community hospital thereby ensuring effective end of life care. This will help negate unnecessary resuscitation attempts.

If the patient is to be discharged to their home address and they are on an end of life plan, the original DNACPR form, after review, will be given to the patient.

When the patient is about to be discharged, and after review of the DNACPR decision, a photocopy of the original form must be placed in the patient’s notes.
All patients with new DNACPR orders for an acute admission, should be rescinded on discharge home unless there has been a recorded discussion with the patient’s community team e.g. GP.

**REVIEWING THE DNACPR ORDER AFTER ADMISSION**

The admitting consultant, during the post-take ward round, must review all DNACPR decisions made out-of-hours for patients under his care. Once a DNACPR decision is in place, it must be reviewed at each ward round to ensure that the patient’s clinical condition has not changed to such an extent that the DNACPR decision is no longer appropriate for that patient.

If the patient’s condition is changing rapidly, then a review of the DNACPR order may be required before the next ward round. It must be remembered that any change in the DNACPR status is effectively communicated to all team members.

A formal review date is not required and each dated entry into the notes will serve as a record that the DNACPR decision has been reviewed and the status quo remains.

If a DNACPR decision is reversed, the DNACPR form must be scored through and cancelled written across it. The yellow section at the bottom of the form **MUST** also be completed.

**RESUSCITATION IN ACCIDENT & EMERGENCY**

The largest group of cardiac arrests within A&E are the continuation of pre-hospital cardiac arrests. The survival from pre-hospital cardiac arrest is very poor but despite this it is not advisable to discontinue resuscitation attempts within the ambulance following a brief assessment.

Therefore, where an ambulance crew is undertaking CPR, a period of advanced life support within A&E is required – the length of this resuscitation attempt will be variable and will depend on information obtained by the team-leader from the attending ambulance crew.

After a successful resuscitation attempt, the team **MUST** discuss the appropriateness of any further resuscitation attempts should the patient re-arrest.

If the decision is made not to resuscitate should the patient re-arrest then a DNACPR form **MUST** be completed.

**COMMUNITY DNACPR DOCUMENTATION / FORMS**

Both the South East Coast and the South Central Strategic Health Authorities have developed community DNACPR forms for use by GP’s and other community medical/nursing staff. These forms slightly differ in appearance to the Trust form.

- South East Coast forms have a red border, red writing and no cancellation box.
- South Central forms are lilac in colour

Despite appearing different from the trust DNACPR form these forms are valid and are a true record of decision-making by the patient’s primary health team.

These forms should be used as an indicator to the wishes of the patient and should be reviewed on arrival with the appropriate review section being completed and also recorded in
the medical notes. An **ASHFORD & ST PETER’S HOSPITAL DNACPR** form must be completed by registrar level or above within 4 hours of admission.

**SPIRITUAL SUPPORT**

The discussion around DNACPR decisions may be a very difficult conversation to have with the patient and his/her family/carers who may appreciate the offer of further support.

The Trust has a Pastoral and Spiritual Care Team and a Chaplain is usually available 24hrs.

He/she can be contacted through the Hospital Switchboard. The on-call Chaplain can assist with contacting the Faith Leader of the patient/family’s choice if this is more appropriate for them.

8. **MONITORING OF COMPLIANCE**

An annual audit of notes will be undertaken by the Resuscitation Services Manager (or their delegate) to monitor compliance with the DNACPR Policy. This will typically involve the review of 1 week’s worth of deceased notes by the Resuscitation Service to ensure DNACPR documentation complies with the trust DNACPR policy.

The audit will include:

- Are decisions clearly recorded in the notes using the DNACPR Form?
- Are the DNACPR forms being completed appropriately and decisions dated and signed by all appropriate personnel?
- Are discussions with family / next of Kin identified?

The audit results will be presented to the Resuscitation Committee and the Divisional Clinical Governance Committees as appropriate by the Resuscitation Service Manager. An action plan will be developed as required, and monitored through the Resuscitation Committee.

Continuous monitoring of cardiac arrest events in the trust is undertaken by the Resuscitation Service. If it is identified that any patient should have been considered for a pre-emptive DNACPR order, this will be reported and action taken in consideration for each individual case. When appropriate an investigation will be undertaken through the trust’s incident reporting system.

9. **EQUALITY IMPACT ASSESSMENT**

See appendix 2

The users of this guideline will take into account their statutory duty to promote equality and human rights and act lawfully within current equality legislation and guidance. This guideline has been equality impact assessed and has been shown to have no adverse impact on any equality group. The Trust will continue to monitor its effect and will assess again if negative impact is identified or at the review date.

In addition this policy is based upon the guidance issued by the South Central and South East Coast Strategic Health Authorities who have also completed separate EIA assessments.
10. REFERENCES AND BIBLIOGRAPHY

Decisions Relating to Cardiopulmonary Resuscitation
A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing October 2014

Standards for Clinical Practice and Training

Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions
Resuscitation Council (UK) July 2009


Mental Capacity Act 2005 London: HMSO 2005
(2005 London TSO)

ALS Course Provider Manual, 6th edition
Resuscitation Council (UK) January 2011

11. APPENDICES

Appendix 1: DNACPR form
Appendix 2: Equality Impact Assessment
APPENDIX 1

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

Attach patient label or print clearly below:
Name: .................................................................
Address: ..................................................................
Date of birth: ..........................................................
NHS number: ......................................................
Hospital number: .................................................

Ashford and St. Peter’s Hospitals NHS Foundation Trust

Date of DNACPR order: / / 

Red Copy Valid with Ink Signature

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) should be made for this person. All other appropriate treatment and care MUST be provided.

1 Does the patient have capacity to make and communicate decisions about CPR?
   YES / NO
   If “NO”, are you aware of a valid advance decision refusing CPR which is relevant to the current condition?
   YES / NO
   If “NO”, has the patient appointed a Personal Welfare Attorney (PWA) to make decisions on their behalf?
   YES / NO
   If “YES”, they must be consulted. (Please state name & relationship of PWA ..........................................................)

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests (please be as specific as possible):

   Transfer from existing DNACPR order? YES / NO
   Is the patient on an end of life care plan? YES / NO

3 Summary of communication with patient (or PWA). If this decision has not been discussed with the patient or if patient lacks capacity, state the reason why:

4 Summary of communication with patient’s relatives or friends:
   (Please ensure that the patient has given consent to discussion with family)

   Name and relationship to patient: .................................................. Date: / /

5 Names and positions of members of multidisciplinary team contributing to this decision:

6 Healthcare professional completing this DNACPR order (Consultant or Registrar)

   Consultant name: .................................................................
   Consultant signature: ..........................................................
   Date: / /
   Bleep / Contact number: ..........................................................

   Registrar name: .................................................................
   Registrar signature: ..........................................................
   Date: / /
   Bleep / Contact number: ..........................................................

   Name of Consultant informed: ..........................................................

7 Review of DNACPR order
   N.B. All DNACPR orders must be reviewed if clinical situation changes and / or weekly.

   Summary of DNACPR review:

   Name: .................................................................
   Position: .................................................................
   Date: / /
   Bleep / Contact number: ..........................................................

   Withdrawal of DNACPR order: Please write ‘CANCELLED’ across form & complete this section fully.
   Reason decision reversed:

   Name: .................................................................
   Position: .................................................................
   Date: / /
   Bleep / Contact number: ..........................................................
# Equality Impact Assessment Summary

**Name:** Paul Wills, Resuscitation Services Manager

**Policy/Service:** Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

## Background

- Description of the aims of the policy
- Context in which the policy operates
- Who was involved in the Equality Impact Assessment

This policy sets out the process to be followed when making decisions in relation to “do not attempt cardiopulmonary resuscitation” orders.

The policy is applicable to all staff and all patients.

Equality Impact Assessment carried out by Paul Darling-Wills, Resuscitation Services Manager.

## Methodology

- A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)
- The data sources and any other information used
- The consultation that was carried out (who, why and how?)

Review of the policy failed to identify any adverse or potentially adverse impacts for any equalities groups.

## Key Findings

- Describe the results of the assessment
- Identify if there is adverse or a potentially adverse impacts for any equalities groups

The policy does not involve any adverse or potentially adverse impacts for any equalities groups.

## Conclusion

- Provide a summary of the overall conclusions

There are no identified adverse or potentially adverse impacts for any group of patients.

## Recommendations

- State recommended changes to the proposed policy as a result of the impact assessment
- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified
- Describe the plans for reviewing the assessment

None.
## Guidance on Equalities Groups

<table>
<thead>
<tr>
<th>Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</th>
<th>Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)</th>
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<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
</tr>
<tr>
<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)</td>
</tr>
<tr>
<td>Culture (consider dietary requirements, family relationships and individual care needs)</td>
<td>Social class (consider ability to access services and information, for example, is information provided in plain English?)</td>
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