Rotherham Doncaster and South Humber NHS Foundation Trust

ADULTS
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Procedure

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Target Audience	All clinical staff working in all service areas including the community. All staff working in areas where patients are present including bank, agency and temporary staff.
Description of change	Changed from a policy to a Procedure within a Manual

1. AIM

The primary goal of medical treatment is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails or ceases to give a net benefit to the patient, or if a patient has competently refused the treatment, this goal cannot be realised and the justification for providing the treatment is removed.

Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient. There are occasions when due to the nature of someone's physical state, and quality of life, a decision may be made that in the event of that person experiencing a cardio-respiratory arrest, cardiopulmonary resuscitation would not be desirable. This includes circumstances where a patient is already dying and has a terminal illness. In these circumstances patients should be allowed to die peacefully and with dignity.

Under the provisions of the Mental Capacity Act (2005), patients with capacity can decide that the stage has been reached beyond which, for them, continued treatment aimed at prolonging life, although possible, would be inappropriate. Patients may have also utilised the provisions of the Act to identify a point in the future after which they do not want treatment, including life sustaining, and refuse further interventions through an advanced decision. Please refer to the Trust's Policy for Advance Statements and Advance Decisions

Under the provisions of the Mental Capacity Act (2005) where patients have no Advance Decision and lack capacity, all decisions about whether to provide treatment must be taken in a way that reflects their best interests. Under the Act, patients have the right to appoint an Attorney to make healthcare decisions on their behalf.

An Attorney can only make life-sustaining treatment decisions if this is made explicit within the Lasting Power of Attorney order. In these circumstances the Attorney must always act in the donor's best interests. (Mental Capacity Act 2005: Code of Practice (2007). Please refer to the Trust's Mental Capacity Act (2005) Policy.

Where the patient who lacks capacity has no relative or friend to support life-sustaining decisions, the Mental Capacity Act (2005) has made provisions for the instruction of an Independent Mental Capacity Advocate (IMCA) to be consulted to support the best interest decision-making process. Please refer to the Trust's Mental Capacity Act (2005) Policy.

Any assessment of best interests must include the patient's clinical presentation and any current and previously expressed wishes and preferences. Where there is no information about their wishes or preferences, decisions must be consistent with and not contrary to their interests or rights. The emphasis on the individual's interests means that it is important that

resuscitation is discussed sensitively with patients who have capacity, and people close to patients who lack capacity including any nominated Attorney. This can help people to understand why treatment is given and why, in some circumstances, it may be unable to provide any benefit.

Each case involves an individual patient with their circumstance, and it is important that these circumstances are central to each decision rather than applying the same decision to whole categories of patients.

Unless a patient who lacks capacity has an appointed Attorney with explicit powers to make decisions regarding life-sustaining treatment, any decision not to attempt resuscitation is ultimately the responsibility of the medical officer in charge of the patient's care (see definition section). Good practice however dictates that consultation should, whenever possible, take place with the other members of the team involved in the care of the patient. Provisions are made under the Mental Capacity Act (2005) and its Code of Practice (2007) for referring decisions to the Court of Protection should professionals' judge that an Attorney is not acting in a donor's best interest. Please refer to the Trust's Mental Capacity Act (2005) Policy.

This Procedure is based on the guidelines produced in 2016 by the British Medical Association (BMA), Royal College of Nursing (RCN) and Resuscitation Council (UK) and should be read in conjunction with this document. It is written with due regard for the requirements of the Mental Capacity Act [2005].

This Procedure should be read in conjunction with the relevant professional standards and guidelines including the Nursing and Midwifery Council (NMC) publication Professional standards of practice and behaviour for nurses and midwives 2015 and the General Medical Council (GMC) publication: Treatment and care towards the end of life; good practice in decision making (July 2010)

This Procedure should be read in conjunction with the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) for Care Groups that have adopted this document in place of the Version 13 DNACPR document.

1.1 Definitions

Cardiopulmonary Resuscitation – (CPR) is a combination of external chest compressions, artificial respiration, and defibrillation. It is undertaken to restore breathing and circulation in a person where these life giving functions have failed.

Do Not Attempt Cardiopulmonary Resuscitation Order – (DNACPR), is an order stating that a decision has been made either by the patient or medical officer in charge of their care that CPR would have no clinical benefit or be wished for in this situation. **It is essential that healthcare professionals, patients and those close to the patients understand that a decision not**

to attempt CPR applies only to CPR and not any other treatment that may be appropriate e.g. antibiotics, analgesia, feeding, hydration, suction, treatment for choking etc.

Medical Officer in Charge of Patient Care, In inpatient care this will be the Patients named Consultant and in the community the patient's GP, unless an agreed service provision is in place.

Healthcare Professional
A Registered Nurse, Doctor, or Allied Healthcare Professional.

Mental Capacity
The ability of an individual to make decisions regarding specific elements of their life. This is also sometimes referred to as 'competence'.

Mental Incapacity
A person lacks sufficient capacity in relation to a matter if, at the material time they are unable to make a decision for themself in relation to the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain. This lack of capacity may be permanent or temporary.

Advance Decisions to Refuse Treatment (ADRT)
A decision made by any person aged 18 years or over, whilst having mental capacity, to refuse specified life sustaining treatment or intervention at a later time, should they lose capacity to make such decisions.

Independent Mental Capacity Advocate (IMCA)
An independent advocate appointed to support vulnerable patients who lack mental capacity and have no one appropriate to act on their behalf. IMCAs can also become involved if staff conclude that relatives/other carers may not be acting in a patient's best interests.

Lasting Power of Attorney (LPA)
A legal document whereby an individual (the donor) authorises another person (the donee) to act on their behalf, in the event that the donor should lose the capacity to make their own decisions. This authority can be in respect of decisions regarding personal welfare and consent to medical treatment. In order to be valid an LPA should be executed on the prescribed form and registered with the Public Guardian. If it applies to end of life decisions this must be clearly stated.

Relevant other
For the purpose of this policy, the term "relevant others" is used to describe patient's spouses, partners, relatives, carers (who are not acting in a paid, professional capacity), representatives, advocates, people with lasting power of attorney, IMCAs and court appointed deputies and any other person deemed to have an interest in the wellbeing of the patient.

Young Person
Within the context of this policy manual and procedures, the term young person refers to any patient aged 16 or 17 years of age.

Child
Within the context of this policy manual and procedures, the term child refers to patients who are under the age of 16.

Best Interests
When a patient has been assessed as lacking capacity, anything done for, or decisions made on their behalf, should be done in their best interest. Best interests are assessed by Healthcare Professionals weighing up the treatment options in the context of the individual patient, once appropriate enquiries have been made of the patient (as far as is possible) and others. Best interest decisions include wider issues than medical issues. Mental Capacity Act 2005: Code of Practice. GMC 2010.

Futility
When treatment is considered unable to produce the desired benefit because it cannot achieve its physiological aim i.e. there is no real prospect of restarting the heart and breathing for a sustained period of time.

2. SCOPE

This Procedure applies to all managers with responsibilities derived from it, and all clinical staff with direct patient contact, including bank, agency, and temporary staff.

NB. This Procedure applies to the DNACPR decision and the completion of the South Yorkshire DNACPR Version 13 (V13) document. For Care groups and clinicians that use the ReSPECT document, please refer to the ReSPECT Procedure

3. LINK TO OVERARCHING POLICY

The Procedure should be read as part of the Resuscitation manual and the associated documents.

- Resuscitation Manual (includes the deteriorating patient, DNACPR adult, DNACPR child and ReSPECT)

4. PROCEDURE

4.1 DNACPR in Inpatient areas.

On admission to an inpatient area it is only necessary to discuss the CPR status of a patient and consider making a Do Not Attempt Cardiopulmonary Resuscitation decision in the following circumstances:

- Where the patient's condition indicates that cardiopulmonary resuscitation (CPR) is unlikely to be successful
- Where successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain
- Where CPR is not in accord with the recorded sustained wishes of a patient who has capacity
- Where CPR is not in accord with a valid applicable written Advance Decision which demonstrates a patient's informed, voluntary and competently made refusal, which relates to the circumstances which have arisen, is legally binding upon medical staff

In cases where a patient is admitted to a ward with an existing DNACPR order, this order will remain but MUST be reviewed on the day of admission and an entry made in the patients notes on the DNACPR template (see Appendix 11). This entry and subsequent entry is to confirm:

- **The existence of the order**
- **The validity of the decision**
- **The validity of the form itself**
- **A review of the patient's capacity in relation to the decision**
- **Patient and relevant others knowledge of the decision**

Any amendments, omissions, or corrections to existing transferred DNACPR orders MUST be made by a consultant at the time of admission.

4.1.1 Responsibility for making DNACPR decisions

In RDaSH consultant led inpatient settings the responsibility for making DNACPR decisions lies with the patients named consultant after consultation with the Multi-Disciplinary Team, patient and relevant others where ever possible.

In St John's Hospice any patients requiring a DNACPR decision on admission may be made by the admitting clinician in conjunction with the nursing team, patient and relevant others wherever possible but **MUST** be countersigned by the patients consultant as soon as is practicable.

4.1.2 Nurse Led units

On admission to a Nurse Led unit the admitting nurse must review any existing DNACPR forms on admission following the points outlined in the previous paragraph (in cases where a patient is admitted with an existing DNACPR) any issues, omissions or concerns with existing DNACPR orders must be discussed with the clinician responsible for the patient's care immediately prior to admission and a document of the conversations made in then patients notes (On the DNACPR template). When the responsible clinician is available, they will review DNACPR's of any new admissions within the overall medical review and make an entry in the patient's notes.

Any DNACPR decisions required during the inpatient stay will be made by the Consultant Geriatrician following the procedure set out in this policy manual and procedures.

4.1.3 Completion of the DNACPR V13 form

All entries into the patient's medical records related to the DNACPR decision should be written on the RDaSH DNACPR template (see appendix 11)

In a situation where the patient's condition meets the above-mentioned circumstances all sections of the form must be completed in full.

If CPR has been discussed with the patient, it is against their wishes, and they have the mental capacity to make this decision, then option **A** should be ticked and a record reflecting the rationale for the decision and capacity assessment should be recorded on the DNACPR template in the patient's electronic records.

If CPR is against the wishes of the patients as recorded in a valid Advance Decision, then option **B** should be ticked. Although the Advance Decision is a legally binding document it is good practice to complete a DNACPR form for ease of communication this must be documented in the patients notes. A copy of the Advance Decision should be kept with the DNACPR.

If the outcome of CPR would not be of overall benefit to the patient, and the patient lacks capacity to make the decision (option A would be appropriate if they had capacity) or they have declined to discuss the decision option **C** should be ticked. This represents a best interest decision and therefore must be discussed with the patient's relevant others or IMCA. The medical officer must document who the decision was discussed with and record the date and time of this discussion on the form. The patient's notes must reflect the full rationale for the decision and choice of option C, the capacity assessment and the thoughts and feelings of the relevant others or IMCA.

If CPR would be of NO clinical benefit option **D** should be ticked and the medical officer must document the medical condition that indicates this decision on the form.

In cases where CPR would be futile due to the patient's condition the decision must be discussed with the patient, unless the patient lacks capacity or has refused to discuss this aspect of their care when discussion has been attempted. It is not acceptable for a discussion not to take place just because this may upset the patient. When making a decision that a discussion is not to take place with the patient the Medical Officer must have a clear rationale that any such discussion would have clear physiological or psychological harm for the patient. If it is not possible to speak to the patient for reasons given above it is important that relevant others are informed of the decision at the nearest possible opportunity. This must not delay the decision, but every effort should be made for discussion with the relevant others. The patients notes must reflect, the medical condition that indicates

this decision, any discussions with patients and relevant others including dates and times, capacity assessment of the patient in regard to the DNACPR decision and a rationale for any delay in discussion with the patient or relevant others with a plan for contact if applicable.

Any meeting convened to discuss the decision must be documented clearly in the patient's notes. The medical officer in charge of the patient's care will take the lead at any meetings and all relevant information about the patient's physical condition and mental state must be available so that an informed decision can be made if not already done so.

An information leaflet about DNACPR must be available to patients and relevant others. This leaflet (found in appendix 10) should be used in circumstances where meetings have been convened to discuss DNACPR as an introduction to the process, where patients have requested discussions about CPR and when a DNACPR decision has been made and the patient and relevant others wish to have information to take away. DNACPR is an emotional subject, and it is often difficult for patients and their relevant others to know what questions to ask. It is often after the discussions that questions arise. The leaflets do not replace face to face discussion and staff must always be available for these discussions if needed.

The ultimate responsibility for such a decision lies with the medical officer in charge of the patient's care. Under no circumstances should a relative, friend or other be asked to, or made to feel that they have to, make the decision. Relevant others should, wherever possible, be involved in the discussions that surround the decision-making process, but, the actual decision is for the medical officer in charge of the patient's care unless a patient with capacity has made the decision either at the time or has made a previous Advance Directive.

In cases where there has been difficulties making the decision, due to relative, family or Multi-Disciplinary Team disagreements it is advisable to obtain a second opinion. In very rare circumstances where there is on-going disagreement it is advisable to obtain legal advice. For more information see the Resuscitation Council UK: Decisions relating to cardiopulmonary resuscitation:
https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf.

Whilst the decision will be based on clinical findings the clinical team will also consider the patient's wishes, including any valid written Advance Decision. If applicable the best interest decision made by a legally empowered Attorney, or a best interest view expressed by an IMCA, must be taken into account. Age, gender, religion, and culture alone will not be factors in the decision.

N.B. under no circumstances will any member of the nursing staff who do not have the authority to make DNACPR decisions meet with the relatives,

attorney, or IMCA alone to make a DNACPR decision. It must **always** be conducted by the medical officer in charge of the patient's care. It may be the case that the initial discussions come from the patients to nursing staff, or it is the nurse that has the better relationship with the patient, in these cases it must be made clear that the decision will be made by the Medical Officer in charge of the patients care following further discussion with them.

For young people aged 16 and 17, also refer to Appendix 6 for further considerations.

4.2 Patients with a DNACPR order on community caseloads.

The responsibility for the DNACPR order in the community lies with the patients GP.

If a patient is discharged from an inpatient facility with a DNACPR order all professionals involved in the patients care should be advised of its existence on discharge.

If a member of staff has cause to question the validity of a DNACPR order in the community this must be brought to the attention of the patients' own GP.

4.3 Communication of the Order

- The order is a two-page carbonated form – Original and copy, (the copy sheet is watermarked appropriately).
- Whilst in inpatient care, the original order should be kept in the front of the nursing notes, the copy (this will only be available if the order was completed whilst an RDaSH patient) will be kept in the front of the medical notes if available. As patients move between care settings, the **original** DNACPR V13 form must move with the patient in a clearly marked envelope.
- In all other care settings, the DNACPR form should be in the front of the care record / nursing record.
- If no nursing record exists in the home, the patient/family/carer will determine the best place to store it. It is then their responsibility to communicate this to the health care professionals.
- In the community DNACPR information should be recorded on the patient's electronic record as part of their Electronic Palliative Care Co-Ordination Systems (EPaCCS) information and locally on their alert screen, this information should include where the patient keeps the DNACPR document. However, it is imperative that this information is used only as an alert to the existence of a DNACPR order. All staff working with the patient must ensure that they have sight of the original form. EPaCCS has a link to the DNACPR template, all parts must be completed.
- Ambulance control should be informed that a DNACPR form exists at the time of booking a patient transport services (PTS) ambulance.
- The discharging organisation will give the original DNACPR form to the patient, ambulance crew or carers in a clearly marked envelope and

inform the patient's GP and all other professionals involved in the patients care of the patients DNACPR status.

- If an ambulance is called in an emergency that is not life threatening but requires transfer to Accident and Emergency (A+E), i.e. from an inpatient ward or patients home. The crew must be handed the care record with the DNACPR form at the front of it, **or** a clearly marked envelope with the **original** DNACPR form in. On arrival at the A+E the crew will hand formally hand-over the DNACPR form to the member of staff responsible for the patient.
- DNACR/CPR status must be discussed on every handover in inpatient services. All staff must be aware of the order and the reasons for the order. All staff must be aware of all patients CPR status, and where appropriate any DNACPR orders and the reasons for the decision. DNACPR information can also be communicated with the use of at a glance boards but must not be displayed in patient's rooms.

The Manager will be responsible for relaying the decision to the rest of the nursing team, ensuring a robust system that will cover all clinicians involved in the person's care.

4.4 Cancellation of Orders

To cancel a DNACPR order, the original form must be marked in black indelible ink with two thick diagonal lines and the word **CANCELLED** should be written across the form with the date and the signature and the name in block capitals of the clinician cancelling the form. A record of the cancellation and a rationale for this decision must be documented in the patient's notes

4.5 Discharge and Movement

On discharge or transfer between areas, e.g. outpatient appointments, any existing DNACPR order should be reviewed, and if still appropriate, communicated to all receiving teams, GP, and ambulance service if appropriate, with the **origina**l copy being sent with the patient on each journey.

The original order should be sent in an appropriately marked envelope if medical notes are not being transferred (Appendix 8)

4.6 Presumption to Resuscitate

"All patients being attended by a clinician, whether in hospital, healthcare unit or their own home, are to be actively and vigorously resuscitated and suitable assistance called, unless they have a 'Do not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place." (Rotherham Doncaster and South Humber Resuscitation Policy 2016).

Where no decision has been made about CPR before any subsequent cardiopulmonary arrest, and the express wishes of the person are unknown it is expected that staff would attempt resuscitation.

"Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported." (BMA, Resuscitation Council (UK), RCN 2014)

It is important to note that Healthcare/Nursing Assistants and all other non-medical non nursing staff **must** commence CPR if a Do Not Attempt Cardiopulmonary Resuscitation Order is **not** in place.

In circumstances where CPR has been initiated without the knowledge of an existing DNACPR or ADRT and these documents then come to light, the continuation of CPR would be inappropriate however the decision to stop must come from a Senior Healthcare Professional (Nurse of Doctor). If there is any doubt, CPR should continue until reviewed by the attending medics. (Paramedic or Doctor).

4.7 Review of DNACPR Orders

When a DNACPR decision has been made, it is the responsibility of the Medical Officer signing the order to set a review date. This date will be dependant and appropriate on the nature of the order and should be set accordingly and documented on the form using **one** of the options;

i) DNACPR decision is to be reviewed by…….(specify date)
ii) DNACPR decision is to remain valid until the end of life.

In addition to the above all DNACPR orders must be reviewed;

- On any change in the patient's condition
- On admission
- prior to discharge

A record of the review must be fully documented in the patient's notes.

As good practice in inpatient areas, DNACPR orders should be communicated on every handover and discussed/reviewed at Ward rounds and MDT meetings.

4.8 Rewriting of orders

Where existing orders have been found to be not valid due to record keeping errors, omissions, or damage to the form during movement etc. and re writing the form is the most appropriate action, an entry in the patient's notes

should be made explaining the rationale of the re write. This rewrite would not necessitate a discussion with the patient or relevant others if there has been no change in the patient's condition, therefore the date of the original discussion should be completed on the form and an entry made in the patients notes. In situations where there is no note of discussion with the patient or relevant others on the exciting form, the admitting team must ascertain the level of knowledge the patient or relevant others has, further discussion maybe needed at this stage. This discussion should be recorded in the patient's notes, but also added to the existing form (the actual date of discussion) this addition will ensure that this conversation is not repeated during any other admissions/movements.

5. APPENDICES

Appendix 6 Young people aged 16 and 17-years special considerations
Appendix 7 Cardio-Pulmonary Resuscitation Decision Making Framework
Appendix 8 DNACPR Form (WZT652)
Appendix 9 Do Not Attempt Cardiopulmonary Resuscitation Communication Sticker
Appendix 10 What Happens If My Heart Stops Leaflet
https://www.rdash.nhs.uk/publications/leaflets/what-happens-if-my-heart-stops-information-for-service-users-and-carers/
Appendix 11 Where to document the DNACPR decision in the electronic records