Policy Number	SSCSD008
Policy Name	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy
Policy Type	Divisional
Accountable Director	Exec Director of Nursing
Author	Richard Moore, Dental Practitioner Updated by Christine McBride (Interim Lead for Respiratory Service)
Recommending Committee	South Sefton Community Services Division Transaction Workforce Work Stream
Approving Committee	Executive Committee
Date Originally Approved	25/05/2017
Next Review Date	01/06/2018

This document is a valid document, however due to organisation change some references to organisations, organisational structures and roles have now been superseded. The table below provides a list of the terminology used in this document and what it has been replaced with. When reading this document please take account of the terminology changes on this front cover

Terminology used in this Document	New terminology when reading this Document
Liverpool Community Health (LCH)	Mersey Care NHS Foundation Trust

To be adopted as a South Sefton Community Division policy as no equivalent currently exists

FOR OFFICE USE ONLY (Work Stream submission check)

This document is compliant with current best practice guidance ☒

This document is compliant with legislation required in relation to its content ☒

What change has this document undergone in the policy alignment process relating to the South Sefton Transaction?

☐ None ☐ Minor ☐ Major ☒ This is a new document

☐ This document has been reviewed and is no longer required

Does this document impact on any other policy documents?

☐ Yes , **if yes, which policies are effected?** Click here to enter text.

☐ No

Signed: **Date: 25/05/2017**

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Liverpool Community Health NHS
NHS Trust

Title:	Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy
Version Number:	2.0
Ratified by: Date of Approval (original version):	Clinical Standards Group 22nd September 2015
Name of originator/author:	Richard Moore, Dental Practitioner Updated by Christine McBride (Interim Lead for Respiratory Service)
Approving Body/Committee:	Clinical Standards Group
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Name of Lead Director/Managing Director:	Medical Director
Changes/Alterations Made To Previous Version (including date of changes):	Changes made • Review due to adoption of NHS North of England North West Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy

1.0 Introduction

1.1 This policy must only be used by individuals who are trained and competent in the application of the Mental Capacity Act (2007) (MCA) and in full accordance with the organizations MCA policy and related guidance or procedures.

1.2 Cardiopulmonary resuscitation (CPR) can be attempted on any adult for whom cardiac or respiratory function ceases. However, in some people this would be inappropriate, futile or against the individuals wishes. It is therefore essential to identify patients for whom cardiopulmonary arrest would represent a terminal event in their illness and for whom CPR is inappropriate. 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 adult to die with dignity. This policy clarifies the position of Liverpool Community Health NHS Trust regarding resuscitation and the process of making DNACPR decisions by LCH staff.

1.3 This policy provides guidance for all LCH clinical staff. It applies across the multidisciplinary spectrum and it is the responsibility of staff members to ensure that they are familiar, and comply, with it.

1.4 Further service specific guidance may be developed to accompany this policy, which will be contained within locally developed Standard Operating Procedures ("SOPs"). Copies of the latest SOPs can be found at http://nww.liverpoolch.nhs.uk/policies-and-procedures.

2.0. Policy Statement

2.1 Liverpool Community NHS Trust DNACPR policy will ensure the following:

2.2 All people are presumed to be ("For CPR'') unless

- A valid DNACPR decision has been made and documented or :
- A valid and applicable Advance Decision to Refuse Treatment (ADRT) prohibits CPR

2.3 Where a patient with capacity refuses CPR or a patient lacking capacity has made a valid and applicable advance decision refusing CPR, this legally binding refusal is respected. This should be fully documented.

2.4 Please note if there is clear evidence of a recent verbal refusal of CPR whilst the person had capacity then this should be carefully considered when making a best interests decision. Good practice means that the verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make an (ADRT) to ensure the verbal

refusal is adhered to.

2.5 A DNACPR decision is not legally binding and does not override clinical judgment. All DNAR decisions are based on legislation and guidance.

2.6 All LCH Healthcare professionals, whether temporary or permanent, are expected to take this policy fully into account when exercising their clinical judgment to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer as appropriate.

2.7 There will be some patients for whom attempting CPR is inappropriate; for example, a patient who is at the end stages of terminal illness. In these circumstances CPR would not restart the heart and breathing of the individual, and should therefore not be attempted. The patient and/or relatives/carers should be informed of this. 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 exceptional circumstances where there is no recorded explicit decision (for example for 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.

2.8 DNACPR decisions should respect the wishes of the individual but individual patients cannot demand treatment against clinical judgment.

2.9 If the patient lacks mental capacity to take part in the discussion and make decisions then the relatives or recognised carers should be asked if the patient had made a previous decision about resuscitation. All discussion and subsequent decisions should be accurately and clearly documented. Patients, family or friends have a right to refuse to take part in the decision.

2.10 The standardized form for adult DNACPR decisions (NWAS unified form) will be used.
(See https://www.nwas.nhs.uk/media/603367/nhs-north-west-dnacpr- policy-v1-4-final.pdf))

2.11 DNACPR decisions refer only to CPR and not to any other aspect of the Individual's care or treatment options/plans.

2.12 Effective communication concerning an individual's resuscitation status will occur between all members of the Multi-Disciplinary Team (MDT) involved in the individual's care and across the range of care settings.

2.13 In order to ensure that the DNACPR decision-making process across LCH is measured, monitored and can be evaluated to ensure a robust governance framework:

2.14 Training will be available to enable staff to meet the requirements of this policy.

2.15 All staff are required to utilize the standardized documentation contained within the appendices of this policy

2.16 This policy will be reviewed periodically by members of the Resuscitation Group, members of the Safeguarding Team, members of Adult Services and the Clinical Standards Group. In addition, it has been reviewed by the LCH legal advisors to the Trust to ensure it provides a robust framework underpinned by the relevant guidance and legislation.

2.17 A DNACPR Decision Algorithm setting out an overview of the DNACPR decision making process is set out at Appendix A.

3.0. Purpose

3.1 This policy will provide a framework to ensure that DNACPR decisions:

- respect the wishes of the individual, where possible
- reflect the best interests of the individual
- provide benefits which are not outweighed by burden

3.2 This policy will provide clear guidance for health and social care staff.

3.3 This policy will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the individual's care or treatment options.

4.0. Scope

4.1 This policy applies to all members of the multidisciplinary healthcare team involved in patient care across all settings within LCH.

4.2 This policy applies to care provided to **all individuals aged 18 and over**.

4.3 This policy forms part of Advance Care Planning for patients and should work in conjunction with end of life care planning for individuals.

5.0. Definitions

5.1 **Cardiopulmonary resuscitation (CPR)** is an emergency procedure which may include chest compressions and ventilations in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation Council (UK) guidelines.

5.2 **Cardiac Arrest (CA)** 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.

5.3 **Respiratory Arrest** is the cessation of normal respiration due to failure of the lungs to contract effectively.

5.4 **Mental Capacity Act – 2005**.

The MCA was fully implemented on October 1st 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.

5.5 **Mental Capacity**: Further information on the Mental Capacity act can be found at Information on the act can be found at http://opera.liverpoolch.nhs.uk/SIRS/Safeguarding%20Documentation/MCA%20Code%20of%20Practice.pdf

5.6 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 who lack capacity will not be able to demonstrate that they can:

- 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 other means

5.7 **Advance Decision to Refuse Treatment (ADRT)** is a decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding.

5.8 **Do Not Attempt Cardio Pulmonary 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/treatments/care such as fluid replacement, feeding, antibiotics etc.

5.9 **DNR** means Do Not Resuscitate.

5.10 **DNAR** means Do Not Attempt Resuscitation.

5.11 **AND** means Allow Natural Death.

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

5.13 **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.

5.14 **A Court-Appointed Deputy**. This is someone who 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 but they cannot make decisions relating to life-sustaining treatment.

5.15 **Standard Operating Procedures are also known as SOPs**. An SOP is a document which **`MUST BE ADHERED TO`.** They are also known as a Mandatory document. Alternatives may be specified within a SOP but deviation from the SOP by LCH staff is not an option.

5.16 **Relevant others**. This term refers to the patient's relatives, carers, and guardian etc.

5.17 This policy covers LCH Trust only.

6.0. LEGISLATION AND GUIDANCE

6.1 Legislation

6.1.1Health care staff are expected to understand how the Mental Capacity Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

6.2 The following provision of the Human Rights Act 1998 is relevant to this policy:

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14)

6.3 Clinicians have a professional duty to report some deaths to the Coroner and should be guided by local practice (Reporting Deaths to the Coroner Practice Directions for Doctors 2014[1].doc as to the circumstances in which to do so but must always report when the deceased has died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.

For more information see:
Coroners, post-mortems and inquests: Directgov - Government, citizens and rights.
http://www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDo Af terdeath/DG_066713

6.4 Equality Impact Assessment

This has been undertaken and the evidence logged with LCH Equality & Diversity Team Guidance. This policy should be read in conjunction with: Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)

6.5 The joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing "Decisions relating to Cardiopulmonary Resuscitation: October 2007" ("the Joint Statement");

6.6 LCH - Mental Capacity Act 2005 Policy;

6.7 LCH – Consent Policy.

7.0. ROLES AND RESPONSIBILITIES

7.1 This policy and its forms/ appendices are relevant to all relevant health care staff across all settings of LCH. It applies to all designations and roles.

7.2 The decision to complete a DNACPR form should be made by a General Practitioner (or Doctor who has been delegated the responsibility by their employer / Health Care Professional with the prerequisite knowledge skill and delegated authority and who has achieved the required competency as defined by LCH) This training and competency must be indemnified by the organisation. LCH must ensure that a DNACPR decision is verified by a professional with overall responsibility at the earliest opportunity.

- Nurses are not currently allowed to make DNACPR decisions in Liverpool Community Health Trust
- The only staff within Liverpool Community Health NHS Trust who have been authorised to make DNACPR decisions are General Practitioners.

7.3 Health care staff should encourage the individual or their representative, where able, to inform those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

7.4 The Chief Executive of LCH is responsible for:

- Ensuring that this policy adheres to statutory requirements and professional guidance
- Supporting unified policy development and the implementation in other organizations.
- Ensuring that the policy is monitored
- Reviewing the policy, form and supporting documentation every two years

- Compliance, both clinical and legal with the regional policy and procedure
- Ensuring the policy is agreed and monitored by the organization's governance process

7.5 Director of Operations/Director of Nursing

- The Director of Operations/Director of Nursing will ensure that this policy is disseminated to appropriate staff groups and that identified training and development needs in relation to the implementation of the policy.

7.6 Medical Director

The Medical Director has overall responsibility to ensure that this policy is implemented and monitored in practice.

7.7 General Practitioner (GP)

The decision to complete a DNACPR form should be made by the GP or other healthcare professional with prerequisite advanced knowledge/skills with the authority to make a DNACPR decision.

It is the responsibility of the GP or such healthcare professional to review a DNACPR decision and inform the team caring for the patient of any review outcomes.

General Practitioners/Doctors making DNACPR decisions must:

- Be competent to make the decision
- Verify any decision made by a delegated professional at the earliest opportunity
- Ensure the decision is documented
- Involve the individual, following best practice guidelines when making a decision, and, if appropriate, involve relevant others in the discussion
- Communicate the decision to other health and social care providers
- Review the decision if necessary

7.8 Other Directors or Managers Responsible for the delivery of care

This group will ensure the implementation of the policy, including that staff are aware of the policy and where to access it, that staff understand the importance of issues regarding DNACPR, staff are trained and updated in this DNACPR policy and related issues and ensure that DNACPR forms, leaflets and policy are available as required.

7.9 All Staff

All staff will ensure that they adhere to the policy and identify any training and development needs in relation to implementation of the policy to their manager. Staff will also check the validity of any DNACPR decision, notify other services of the DNACPR decision or an

advance decision to refuse treatment, including an advance decision to refuse CPR on the transfer of patient as required and participate in any audits.

Where CPR will be of no benefit for the patient, it is the responsibility of the medical and MDT Team to ensure that the patient and family have the opportunity to be made aware of the severity of the patient's condition.

7.10 The Individual Patient

The individual patient should inform, where able and where applicable, those looking after them that they have appointed a Lasting Power of Attorney or that there is a valid documented DNACPR decision about themselves and where it can be found.

7.11 Role of Resuscitation and Mortality Group

This is a sub group of the Patient Safety Sub-Committee which meets a minimum of 4 times a year and is chaired by the Medical Director of the organization.

8.0. An overview of Cardio Pulmonary Resuscitation ("CPR")

8.1 CPR interventions are delivered with the intention of restarting the heart and breathing. Such interventions include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

8.2 CPR is a relatively invasive medical therapy that usually includes external chest compression, artificial respiration and defibrillation. These measures should be immediately instituted by local staff and should be followed by an emergency call and other active resuscitation measures.

8.3 The survival rate after cardio respiratory arrest and CPR is relatively low. Public perception of survival rates after cardio respiratory arrest and CPR is often not evidence-based and tend to be much higher than is realistic.

8.4 Furthermore, the Joint Statement confirms that attempting CPR carries a risk of significant adverse effects including but not limited to rib or sternal fractures, hepatic or splenic rupture or prolonged treatment in an intensive care unit, possibly including prolonged artificial ventilation. It can also be traumatic, meaning that death occurs in a manner that the patient or people close to the patient would not have wished.

8.5 There is a general presumption in favour of providing CPR, unless a patient with capacity refuses CPR or a patient lacking capacity has a valid and applicable advance decision refusing CPR.

8.6 However, as with any decision to provide treatment, the decision to provide CPR should be based on the balance of burdens, risks and benefits to the individual receiving the treatment. Where death is expected as an inevitable result of underlying disease and/or it is not clear whether or

not CPR might restart the heart and breathing of the individual, it may not be appropriate to attempt CPR. Discussions should take place with that individual patient wherever possible (and/or with other appropriate individuals where the patient lacks capacity in accordance with the Mental Capacity Act 2005 ("MCA") as to whether CPR should be attempted.

8.7 In situations where it is decided that CPR measures would not be successful, it may still be appropriate to provide analgesia, antibiotics, and drugs for symptom control, feeding or hydration (by any route), investigation and treatment of a reversible condition, seizure control, suction and treatment for choking. Comfort and treatment measures are instituted after assessment, consultation with the patient and relevant others, and on the basis of clinical need.

9.0. Status

9.1 A DNACPR decision (also known as "a DNACPR order") is not legally binding, unlike a valid and applicable advance decision to refuse CPR made by a patient with capacity.

9.2 A DNACPR decision provides clinical advice as to whether, should the patient be in cardiac or respiratory arrest, CPR should be attempted.

9.3 Where, as is usually the case, a patient lacks capacity to consent to CPR at the time of cardiac or respiratory arrest, the treating clinician's judgment of best interests at the time that the decision to provide CPR arises, prevails. It may, for example, be appropriate for the clinician to decide to provide CPR on the basis that the circumstances envisaged at the time of making a previous DNACPR decision have changed.

9.4 LCH End of Life Documentation vs. DNACPR. The use of End of Life Documentation will always take precedence over a DNACPR order. However best practice and effective advanced care planning would ensure that the decision DNACPR will have been made prior to this. Datix should be completed if patient enters the terminal phase and subsequently dies without a uDNACPR form in place.

10.0. Patients are individuals

10.1 It is important that each patient is treated as an individual and that his/her situation and circumstances are given careful consideration. Both considerations are essential and should be central to any DNACPR decision made relating to a particular patient.

10.2 Decisions about CPR must be made on an individual assessment of each patient's case based on an objective assessment of what is in the best interests of the patient, taking into account all relevant factors, including the patient's own views. A DNACPR decision should be made only after appropriate consultation and consideration of all relevant aspects of a particular patient's condition, such as:

10.3 Likely clinical outcome of attempting CPR, including the likelihood of successfully restarting the patient's heart and breathing and the overall benefit achieved from a successful resuscitation.

10.4 Patient's known, ascertainable wishes.

10.5 Patient's human rights.

10.6 Where the patient lacks capacity, the views of others such as family or carers, also the person's past and present wishes, feelings, beliefs and values.

10.7 DNACPR decisions must not be made on the basis of assumptions based solely on factors such as the patient's age, disability status or on a professional's subjective view of a patient's quality of life. It must not be assumed that the same decision will be appropriate for all patients with a particular condition.

11.0. Capacity

11.1 A person must be assumed to have the capacity to make a decision, unless it can be established that they lack capacity. Assessments of capacity should be carried out in accordance with the Mental Capacity Act 2005. Further details are provided in the LCH Mental Capacity Act 2005 Policy.

11.2 At the time when CPR is required the person will usually lack capacity:

11.3 If a patient has a valid and applicable advance decision to refuse CPR then this is legally binding and should be treated as a contemporaneous refusal of consent to treatment and must be respected.

11.4 If a patient has a Lasting Power of Attorney (LPA) in place which authorizes a Welfare Attorney to make decisions to refuse CPR, the decision of the Attorney is legally binding. Where a Deputy has been appointed by the Court of Protection to make such decisions, the decision of the Deputy is legally binding. In such cases, a copy of the LPA or order authorizing the Deputy to make such decisions should be obtained and reviewed.

11.5 If a person lacks capacity to make a decision with regard to CPR and has not made a valid and applicable advance decision or appointed a Lasting Power of Attorney who is able to do so on their behalf, any DNACPR decision relating to him/her must be made in their best interests, in accordance with the Mental Capacity Act 2005.

11.6 As set out above, a DNACPR decision can be helpful to identify whether CPR is likely to be in a person's best interests in the event of cardiac or respiratory arrest. Such events are often unexpected and require prompt action if CPR is to be attempted, thus making best

interests assessments about providing CPR, at that time, difficult. However, a DNACPR decision is not legally binding and the treating clinician's judgment of best interests at the time that the decision about provision of CPR must be made prevails.

12.0. Timing

12.1 Cardiopulmonary arrests can be sudden, unpredictable, and require an immediate response if treatment is to be successful. Therefore, decisions concerning the appropriateness of undertaking a CPR attempt should, wherever possible, are considered before the patient goes into cardiac arrest, ensuring the consideration of all relevant legal principles and guidance, and so that any DNACPR decision can be correctly communicated to all appropriate staff.

12.2 If the risk of cardio respiratory arrest is considered very low, it is not necessary to initiate discussion about CPR with a patient (and/or with those close to patients who lack capacity) unless the patient/those close to them wishes to do so.

12.3 If there is an identifiable risk of cardiac or respiratory arrest, either because of an underlying incurable condition (such as cancer), because of the patient's medical history (such as recent myocardial infarction or stroke), or current clinical condition (such as severe sepsis) it is desirable to make decisions about CPR in advance whenever possible.

12.4 Advance care planning (e.g. Preferred Priorities of Care (PPC), including making decisions about CPR, is an important part of good, clinical care for those at risk of cardio respiratory arrest. Proper communication and the provision of information are essential parts of that care.

13.0 Making a DNACPR decision - adults

13.1 Where the expected benefit of attempted CPR may be outweighed by the b u r d e n , the patient's informed views are of fundamental importance.

13.2 Where the patient has capacity

13.2.1 Where competent patients are at foreseeable risk of cardiopulmonary arrest or have a terminal illness, there must be a sensitive exploration of their wishes regarding their own resuscitation.

13.2.2 The Mental Capacity Act 2007 ("MCA") governs assessments of capacity and decisions relating to individuals who lack capacity. For further information, please see the LCH Mental Capacity Act 2007 Policy. The MCA states that a person must be assumed to have capacity unless it is established that they lack capacity.

13.2.3 On the assumption that a patient has capacity and has validly refused treatment it is unlawful in those circumstances to provide treatment for

him/her without his/her consent.

13.2.4 If a patient with capacity does not want to be resuscitated in the event of cardiac or respiratory arrest, the GP responsible for that patient's treatment should be informed immediately. The GP should ask the patient whether they have made or wish to make an advance decision to refuse CPR or whether they have appointed a Lasting Power of Attorney to make decisions about CPR for them.

13.2.5 Staff must ensure that any advance decision to refuse CPR and/or appoint a lasting Power of Attorney is fully and clearly recorded within healthcare records and at the base of the community team as indicated and communicated to the treating clinical team as appropriate. A copy of the advance decision or the Lasting Power of Attorney should be available on the healthcare records.

13.2.6 Some patients may ask for CPR to be attempted, even if the clinical evidence suggests that, in their case CPR will not effectively restart the heart or breathing or that it cannot provide any overall benefit. Sensitive efforts should be made to ensure that the patient has a realistic view of what happens during a CPR procedure and what the likely outcome could be. Some patients may remain adamant in their wishes despite the clinical chances of success being very small. It should be remembered that doctors cannot be required to give treatment contrary to their clinical judgment. The aim of discussions between the patient and team members should be to secure an understanding and acceptance of any decision about CPR that is made**.**

13.2.7 Where a clinical decision is made that CPR should **not** be attempted, the patient (and, with the patient's consent, those close to them) should ordinarily be informed of the decision and involved in making a DNACPR decision in an appropriately sensitive manner.

13.2.8 Making a DNACPR decision without the patient's explicit and informed consent should be the exception. It should only be done where the patient has clearly expressed a wish not to discuss CPR. A patient must be given sufficient information to understand that they are effectively opting out of the decision making process. A record should be kept of the discussions held with the patient and the patient's decision not to discuss or make a decision about CPR.

13.2.9 Where a clinician believes that a DNACPR decision should be made but the patient opposes that decision, legal advice should be sought.

13.3 Where the patient lacks capacity and has not made a valid and applicable advance decision or appointed a Lasting Power of Attorney

13.3.1 The MCA sets out a 2 stage test for assessing a person's capacity to make a decision.

13.4 Consultation

13.4.1 In order to assess best interests, the views of those close to the patient should be sought, unless this is impracticable or inappropriate. Family and friends are extremely useful in ascertaining prior wishes of the patient and this can be helpful to the doctor in arriving at a best interest's decision. Such consultation can help to determine any previously expressed wishes of the patient and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR.

13.4.2 It is a statutory requirement that anyone engaged in caring for the patient or interested in his/her welfare (such as family and friends) are consulted if a patient lacks capacity and the doctors wish to made a decision on their behalf in his/her best interests.

13.4.3 It is a common misconception that a patient's named "next of kin," family and/or friends close to patients have the final say as to whether CPR for a patient who lacks capacity should be attempted. However, no person is legally entitled in England to give valid, legally binding consent to medical treatment on behalf of another adult patient who lacks capacity to make that decision unless there is a Lasting Power of Attorney or they are appointed as their Deputy by the Court of Protection.

13.4.4 Furthermore, family, friends, Lasting Powers of Attorneys and/or Court appointed Deputies **cannot** demand treatment that is clinically inappropriate.

13.4.5 If an adult patient lacks capacity and has no family, friends or other advocate with whom it is appropriate to consult on a decision concerning "serious medical treatment," other than a paid carer, the MCA requires that an **independent mental capacity advocate (IMCA)** must be consulted.

13.4.6 "Decisions concerning 'serious medical treatment" would include whether or not CPR should be provided or if a DNACPR decision is being considered on the balance of benefits and burdens.

13.4.7 It should be noted that an IMCA does not have the power to *make* a decision about CPR but must be *consulted* by the clinician in charge of the patient's care as part of his/her determination of, and decision in, the patient's best interests.

13.4.8 Details of such consultation should be recorded in the patient's medical records and minutes should be taken of any best interests meeting that takes place.

13.5 Disagreement over a DNACPR decision

13.5.1 Where there is a disagreement between the treating clinician and

the patient, relatives or carers as to whether a DNACPR decision should be made, a second clinical opinion should be sought.

13.5.2 Where the disagreement cannot be resolved, the Medical Director or Senior Managers should be contacted during office hours.

13.5.3 Where a disagreement arises outside of office hours, which requires urgent resolution, the Director on call should be contacted.

13.5.4 Legal advice may be necessary, which can be accessed via the Medical Director, Senior Managers or Director on call as applicable.

13.5.5 If an emergency situation arises before a resolution of the disagreement has been reached, there should be a presumption in favour of preserving life and maintaining the status quo from a clinical perspective until such advice can be obtained.

14 Human Rights

14.1 In order to meet their obligations under the Human Rights Act 1998, health professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention.

14.2 Provisions particularly relevant to decisions about attempted CPR include:

14.2.1 The right to life (Article 2)

14.2.2 To be free from inhuman or degrading treatment (Article 3)

14.2.3 Respect for privacy and family life (Article 8)

14.2.4 Freedom of expression, which includes the right to hold opinions and to receive information (Article 10)

14.2.5 Freedom from discriminatory practices in respect of these rights (Article 14).

14.3 The spirit of the Human Rights Act 1998, which aims to promote human Dignity and transparent decision making, is reflected in this ethical policy. If any concerns arise regarding the application of a DNARCPR decision, the senior doctor in charge of the patient's care should be informed. If concerns still apply, the Medical Director should be informed and the advice of the Trust's legal advisors should be sought.

15.0 Documenting and communicating the decision

15.1 Discussions regarding CPR and whether or not to attempt it are highly sensitive, complex and can be very upsetting for all involved.

15.2 Written Information on DNACPR is available to all patients on admission to services provided by LCH and can be found on the intranet. This leaflet explains the process by which such decisions are made. Patients should be encouraged to see such information as a routine part of advance care planning to cover all contingencies. This information is intended to reassure patients of their part in decision making and should contain questions and answers that they would not think of asking and also clarify to the patient that the need to discuss resuscitation may not arise.

15.3 Support for patients and those close to them during these discussions should come from similarly experienced nursing colleagues.

15.4 Where such discussions are necessary, they should be undertaken by senior, experienced members of the medical team including healthcare professionals with prerequisite advanced knowledge/skills but the final decision remains the responsibility of the General Practitioner.

15.5 All patients and those close to them can ask for time to be set aside to discuss the issues regarding CPR and DNACPR decisions with the MDT team caring for them.

15.6 In order to communicate information about DNACPR decision with non- English speaking BME and other minority ethnic populations, appropriate interpretation services **must** be provided.

15.7 It is not the healthcare teams` responsibility to decide how much information the patient should receive, their task is to find out how much the patient wants to know or understand and to provide that to them.

15.8 Any benefits of providing CPR should be given to the patient on the best available information, but patients should be informed, sensitively, of the inherent uncertainty and risks surrounding CPR so that they have a realistic understanding of the risks and benefits of the decision to be made and what the procedure itself involves.

15.9 Where a DNACPR decision is being made:

15.9.1 Patients should ordinarily be informed of the DNACPR decision being made and being placed in their medical notes/shared with their treating clinical team. Such communication should be conducted in an appropriately sensitive manner. The only exception is where the patient has clearly declined to be provided with such information. Such decisions should only be made after the patient has been informed of the implications of that refusal (i.e. they are opting out of the decision making process) and should be documented.

15.9.2 Where the patient lacks capacity (or where a patient with capacity requests that others close to them are involved in their care), those

individuals who have been consulted in making the decision that CPR is not in the patient's best interests should be informed of the decision and how it will be communicated amongst the treating clinical team.

15.10 It should be made clear to the patient and healthcare team that making a DNACPR decision does not imply "non-treatment" and all other treatment and care appropriate to the patient will continue and evaluated as per care plans.

16.0 Recording a DNACPR decision

16.1 Once the DNACPR decision is made, the supervising clinician in charge of the patient's care is responsible for ensuring that it is recorded on the North of England North West approved DNACPR form(Lilac form) (Appendix B) is completed, staff treating the patient are informed and the original form is to stay with the patient. Ensure that the details recorded on the top copy of the DNACPR form (i.e.) Lilac Form) have carbon copied clearly on to the other two copies, which should be placed within the patient's records.

16.2 The DNACPR decision and surrounding conversations should also be documented as per LCH Record Keeping Policy.

16.3 If the patient is transferred between healthcare providers the DNACPR form should accompany the patient at all times.

16.3.1 If the patient is transferred to another ward/hospital or another medical team/clinical team whether part of LCH or not, the decision should be reviewed by the receiving ward/hospital/team. The decision will remain in place until rescinded by the new medical team/clinical team.

16.3.2 When a patient is received into primary care with a DNACPR decision, this order must be reviewed by the GP in charge of the patient and the decision communicated to all those involved in the patient's care.

16.3.3 When transferring a patient, the original DNACPR form should stay with the patient, the other two copies should remain filed in the accompanying medical notes/patient record. On no account should the DNACPR forms be photocopied. The receiving institution is informed of the DNACPR decision.

16.3.4 If the patient is taken off LCH premises and is accompanied by a member of LCH staff, the original DNACPR decision must travel with the patient where possible and in any event, the LCH staff should be familiar with the DNACPR decision.

16.3.5 LCH are required to compile local Standard Operating Procedures which will set out systems and processes for the transfer of patients between healthcare providers. (See intranet for most up to date copy)

16.4 It is the medical and nursing team's responsibility to ensure that the patient's family is aware of the existence of the DNACPR decision and know what to do in the event of the patient's death.

16.5 Where it is felt that it may be harmful to the patient to have the DNACPR decision in the home, the GP should keep the form in the front of the medical notes and ensure that all the healthcare professionals involved in the patient's care are aware of this.

16.6 The staff working within out of hours services of LCH must be aware of the existence of the DNACPR decision. Every effort must be made to ensure the emergency services are not called inappropriately when a patient has died and **THEIR DEATH IS EXPECTED.**

17.0 Implementation of a DNACPR decision

17.1 As set out above:

17.1.1 Where a patient with capacity refuses CPR or a patient lacking capacity has made a valid and applicable advance decision refusing CPR or a Lasting Power or Attorney with the power to make decisions about CPR refuses it, this legally binding refusal must be respected.

17.1.2 Where a patient lacks capacity and has not made a valid Advance Decision to Refuse CPR or there is no Lasting Power of Attorney authorizing an Attorney to make the decision, DNACPR decisions about that patient must be made in their best interests. At that stage, any DNACPR decision must be considered.

17.2 A DNACPR decision is clinical advice. It is **not** legally binding (unlike a valid and applicable Advance Decision by the patient to refuse CPR or a decision by a validly appointed Lasting Power of Attorney who is able to make decisions about CPR).

17.3 A DNACPR decision that has been made and recorded appropriately in accordance with this policy should usually be followed in the event of a cardiac or respiratory arrest. However, a DNACPR decision does not override clinical judgment in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged at the time of making the DNACPR decision.

17.4 Where a DNACPR decision has not been recorded in the Medical records or there are doubts over its continued application and time does not allow an assessment of the patient's best interests, CPR should be undertaken in order to save life. In such cases this must be recorded via DATIX and line manager informed or out of hour's manager as appropriate.

18.1 Reviewing DNACPR decisions

This decision will be regarded as **'indefinite'** unless:

- A definite review date is specified
- There are improvements in the person's condition
- Their expressed wishes change where a 1b & 1c decision is concerned

If a review date is specified then the health care staff with overall responsibility must contact all relevant on-going care givers to inform them of the need for a review.

This contact must initially be by phone/in person and then followed up with a discharge letter to ensure that the details of the review are clear to all concerned. Informal reviews can take place at any time if they are felt appropriate reasons for the review, or refusal to do so, should be clearly documented, along with the outcome of any review.

19 Suspension of a DNACPR Decision

19.1 In some circumstances there are reversible causes of a cardio- respiratory arrest. These are either pre-planned or acute.

19.2 Uncommonly, some patients for whom a DNACPR decision has been established may develop Cardiac Arrest from readily reversible cause. In such situations CPR would be appropriate, while reversible cause is treated, unless the patient has specifically refused intervention in these circumstances

19.3 **Pre-planned.** Some procedures could precipitate a cardiopulmonary arrest for example induction of anesthesia, surgical procedures etc. Under such circumstances the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether suspend the DNACPR decision and, if so, for how long. The patient and those close to them should be appropriately involved in and informed of this review and the outcome of it. The decision must be recorded and communicated appropriately to all members of the treating clinical team.

19.3 **Acute.** Where the person suffers an acute unforeseen but immediately life threatening situation, such as anaphylaxis or choking, CPR would be appropriate while the reversible cause is treated.

20.0 Cancellation of a DNACPR Decision

20.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form should be crossed through with 2 diagonal lines in black ink and the word **`CANCELLED`** written clearly between them, dated and signed by the healthcare professional cancelling the decision.

20.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed

of the original decision.

20.3 Electronic versions of the DNACPR decision must be cancelled as per guidance above.

20.4 Details of the decision to cancel the DNACPR decision and surrounding conversations should also be documented as per LCH Record Keeping Policy.

21.0 Training

Mandatory training to fulfill this policy will be provided in accordance with local Services Training Needs Analysis. Management of training will be in accordance with LCH Mandatory Training Policy.

22 Monitoring of compliance

The monitoring process for this document is as per **Appendix C– Monitoring Framework** contained within this policy.

23 References and Bibliography

British Medical Association, resuscitation Council (UK), Royal College of Nursing (2007). *Decisions relating to Cardiopulmonary resuscitation: a joint statement from BMA, RC (UK) & RCN. Available from* *www.resus.org.uk/pgs/dnar*

NHS South Central. Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy. March 2010. Accessed August 2012.

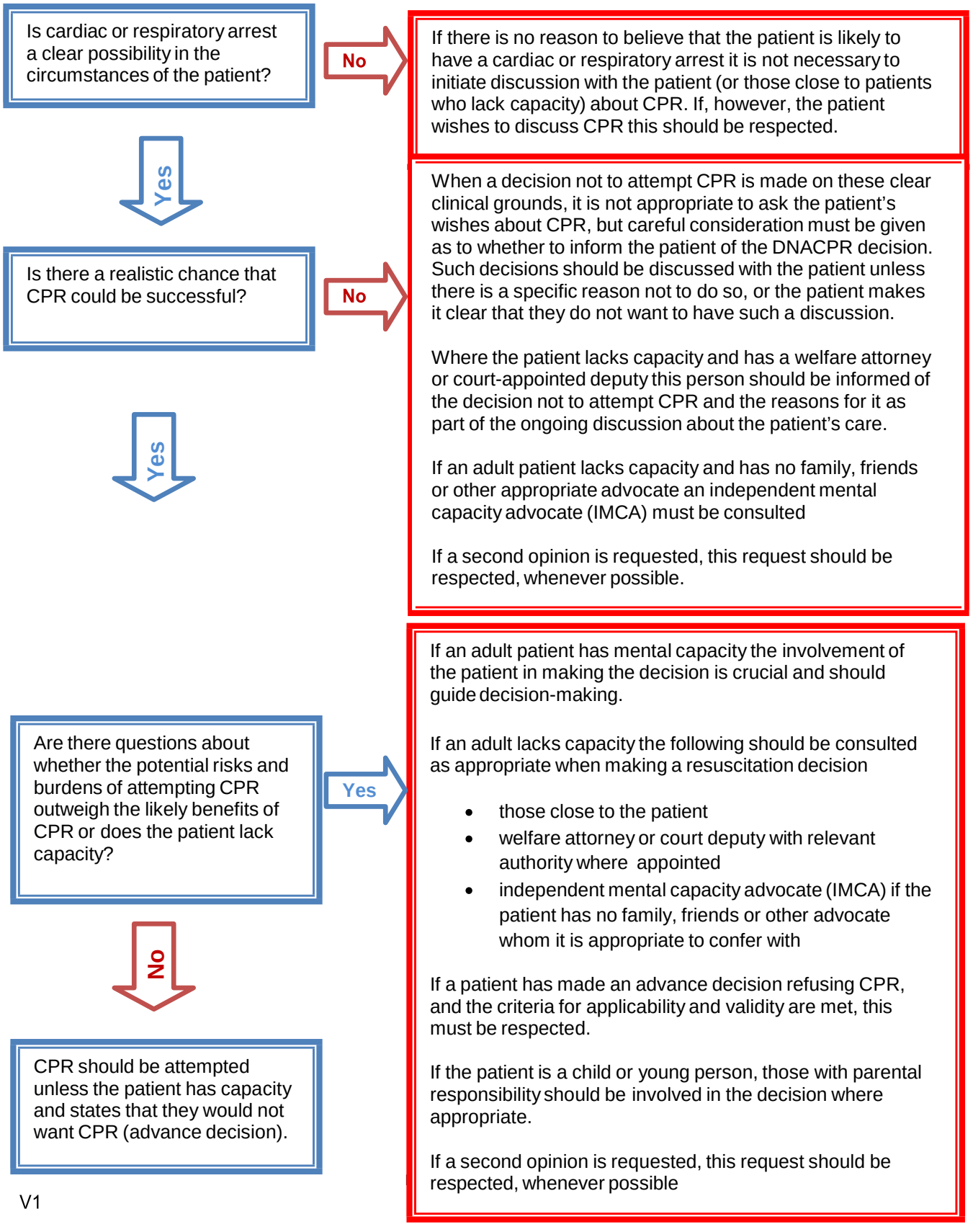
The Mental Capacity Act. Easy Read Summary (2006) & related Code of Practice http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/menincap/mca-act- easyread.pdf

National Confidential Enquiries Perioperative Death (NCEPOD). 2012. *Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardio respiratory arrest.*

NHS Rotherham Community Health Services. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy v2. Accessed August 2012.

Appendix A. DNACPR Decision Algorithm

Adapted from 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)



Appendix B

Advance Statements and ADRTs

Advance Statement

This is a statement of a patient's views and wishes, indicating preferences and what forms of medical treatment a patient would or would not want to receive should they be unable to communicate their wishes at a later date. It does not need to be a written statement but if a patient has strong views about what treatment they would or would not want in certain future circumstances, they should be encouraged to discuss their views with medical or nursing staff so that it can be documented for future reference. Patients may wish to consider making an advance decision to refuse treatment (discussed below). An advance statement can also be used to indicate an individual that the patient would like to be consulted regarding their wishes on a particular matter if the patient lacks capacity to make that decision themselves. Patients should be made aware that such nominated individuals would not have the legal power to make decisions for the patient. If the patient wishes to grant such legal power, they should consider conferring a Lasting Power of Attorney on that individual, under the Mental Capacity Act 2005.

An advance statement of this nature is not legally binding but would be taken into account if the patient lost capacity and it was necessary to make a decision on that patient's behalf in their best interests, in accordance with the Mental Capacity Act.

Where an advance statement relates to the patient's wish to not have cardio-pulmonary resuscitation in the event of a future unexpected cardiac and/or respiratory arrest, a DNACPR form may not be appropriate and a patient should be encouraged to make an advance decision to refuse treatment (ADRT). In the event of an unexpected cardiac or respiratory arrest, and (as is likely) the patient lacks capacity at that time to decide whether to consent or refuse CPR a valid and applicable advance decision to refuse CPR is legally binding If such an advance decision to refuse CPR is not made, their wishes not to have CPR in the event of an unexpected cardiac or respiratory arrest would be taken into account in determining whether, in their best interests, such CPR should be given but, whilst persuasive, they are not legally binding.

Advance Decision to Refuse Treatment (ADRT)

These are a particular type of statement made under the Mental Capacity Act by a person refusing a form or forms of medical treatment should they lack capacity to consent or refuse that treatment in the future.

It can only be made by a person with capacity who is aged over the age of 18.

It does not need to be a written statement unless it relates to life sustaining treatment. However, a patient should be encouraged to discuss their advance decision with medical or nursing staff so that it can be documented for future reference.

A decision to refuse CPR is a decision to refuse life sustaining treatment and, as such, the following additional legal requirements must be fulfilled for the advance decision to be valid:

i) it must be in writing

ii) it must be signed by the patient (or in their presence if they are unable to do so themselves)

iii) It must be witnessed

iv) It must include a statement that the decision is to apply even if life is at risk

If any of the above 4 requirements are not met, the advance decision is not legally valid. However, it will still be something that needs to be taken into account as a strong indication of the patient's views and wishes when they had capacity, in relation to any best interests decision made once they lose capacity.

If valid (e.g. it was not subsequently withdrawn) and applicable (e.g. the circumstances envisaged at the time it was made arise and there are no grounds to believe that there has been a change in circumstance which would affect the patient's decision if he/she would have known about it at the time of making the decision), the advance decision is legally binding.

More information about ADRTs can be found on the NHS end of life care website which gives details of how to draw up an ADRT and offers templates etc.

An advance statement of any kind may not be used by a patient to do the following:

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

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

3. Refuse the offer of basic care such as the offer of food and drink by mouth (although an advance decision can refuse artificial nutrition and hydration).

Where there is doubt or disagreement regarding the patient's capacity to make an advance decision, its validity or its application with regard to withholding or administering treatment, legal advice should be sought. It may be necessary to apply for a Court declaration

Appendix C – Monitoring Framework

Requirement to be monitored	**Process for monitoring**	**Responsible Party**	**Frequency of monitoring**	**Reporting, Action taken and monitored by**
Do not attempt resuscitation orders (DNAR)	Record Audit	Individual clinical services	Yearly	Divisional Governance meetings
How the organization documents that resuscitation equipment has been risk assessed for competency levels and is included on an asset inventory list, with history of maintenance and repair, stocked appropriately and fit for use	Audit of equipment check reports from itemized asset inventory lists	Medical Devices & Equipment Safety Group	Yearly	Medical Devices & Equipment Safety Group

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