

# DECISIONS RELATING TO CARDIO PULMONARY RESUCITATION

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| Version 8  | November 2010  | Physical Health Group  | Draft  | Updated in line with Resuscitation Guidelines 2010  |
| Version 6  | 2008  | Duncan Gilbert  |   |   |
| Version 5  | April 2007  | Sue Simister/Eirlys Evans  |   |   |

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**Do Not Attempt Resuscitation (DNAR) - Practice Guidelines**

#  1. INTRODUCTION

1.1 Cardio Pulmonary resuscitation (CPR) was introduced in the 1960’s when it was recognised that as a treatment that for some people may re-start their heart when they suffer a sudden cardiac arrest due to a heart rhythm disturbance, most commonly triggered by acute myocardial infarction (‘heart attack’) from which they would otherwise have been expected to make a good recovery

1.2 The probability of success in any individual is influenced by other factors and in many people with advanced chronic disease the likelihood of CPR being successful is relatively low

1.3 Decisions about whether or not cardio – pulmonary resuscitation will be attempted raises distressing and emotional issues for patients and families.

1.4 New guidance was issued in October 2014 by the Royal college of Nursing and the British medical association regarding decisions about whether or not to attempt CPR on a person when their heart stops or they stop breathing.

1.5 The new edition of the guidance makes clear that with good, sensitive communication from staff; individuals can plan, make their wishes known, and understand the consequences of decisions around resuscitation attempts”.

1.6 This guidance takes account of developments in clinical practice and law regarding decisions about CPR

1.7 All CPR decisions should be made on an individual basis and guided by the law .The highlevel ethical principles are the same for all people, in all settings, but differences in clinical and personal circumstances will inform the decision. A central tenet of the mental capacity legislation in England and Wales is ‘best interest” and could be used when considering decisions

*Note: This guidance should be read in conjunction with Decisions relating to cardiopulmonary resuscitation published in 2014 [2016] by the RCN and BMA*.

## 2.0 SUMMARY

2.1 Considering whether or not to attempt CPR is an important part of care for any person approaching end of life and might best be considered in advanced decision making.

2.2 Every decision about CPR must be made on the basis of a careful assessment of each individual’s situation.

2.3 Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or of those close to the patient. However there is a presumption in favour of informing a patient of such a decision. The patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.

2.4 Making anticipatory decisions about CPR as an integral part of good clinical practice: leaving people in the ‘default’ position of receiving CPR should they die, regardless of their views and wishes, denies them of the opportunity to refuse treatment that for many may offer no benefit and that many may not want;

## 2.2 *Review*

2.2.1 The Trust recommends that Do Not Attempt Cardio - Pulmonary Resuscitation Forms DNACPR are updated and reviewed annually as a minimum.

2.2.2 Triggers for review should include any request from the patient or those close to them, any substantial change in the patient’s clinical condition or prognosis and transfer of the patient to a different location

2.2.3 Where a decision is made regarding CPR because of an acute episode of care this decision should be regularly reviewed.

## 2.3. *Communication*

2.3.1 Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved.

2.3.2 There should be clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them.

2.3.3 Any decision about CPR should be communicated clearly to all those involved in the patient’s care.

## 2.4 *Understanding*

2.4.1 It is essential that healthcare professionals, patients and those close to patients understand that a decision not to attempt CPR applies only to CPR and not to any other element of care or treatment. A DNACPR

##  2.5 *Documenting*

2.5.1 All decisions relating to ~~DNAR and~~ DNACPR should be **documented** clearly in the notes and on the recommended Trust form

## 3.0 DNACPR APPLIES ONLY TO CPR

3.1 A decision not to attempt CPR applies only to CPR. All other appropriate treatment and care for that person should continue**.**

## 4.0. MAKING THE DECISION

4.1 Overall responsibility for a "Do Not Attempt Cardio Pulmonary Resuscitation" (DNACPR) decision rests with the consultant or GP in charge of the patient's care.

4.2 Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

4.3 Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and, where appropriate, explained to the patient and those close to the patient at the earliest practicable opportunity

## 4.4 Adults who lack capacity

4.4.1 Where a patient has not appointed a welfare attorney or made an advance decision, the treatment decision rests with the most senior clinician responsible for the patient’s care. Where CPR may re-start the patient’s heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient’s best interests (or ‘benefit’ in Scotland). In order to assess best interests, where possible the views of those close to the patient must be sought, to determine any previously expressed wishes 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.

4.4.2 In reaching a decision:

4.4.3 In **England and Wales** the Mental Capacity Act requires that best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, and anyone engaged in caring for the person or interested in the patient’s welfare. Under the Act, all healthcare professionals must act in the best interests of a patient who lacks capacity.

•4.4.4 People with a welfare attorney or court-**appointed deputy or guardian**

 If people lack capacity and have a welfare attorney or guardian, this person must be consulted about CPR decisions that are made on a balance of benefits and risks. However, if CPR would not be successful, welfare attorneys and guardians should be informed of the resulting DNACPR decision and the reasons for making it

## 5.0 ADVANCED DECISION MAKING

5.1 Healthcare professionals have an important role in helping people to participate in making appropriate plans for their future care in a sensitive but realistic manner, making clear whether or not attempted CPR could be successful. Helping people to have a better understanding of CPR in their situation, when appropriate, and to clarify their wishes in respect of CPR should be regarded as a marker of good practice in all healthcare settings**.**

5.2 If there is a risk of cardiac or respiratory arrest, it is important to make decisions about CPR in advance whenever possible.

5.3 In some cases there is an identifiable risk of cardiac or respiratory arrest, either because of an underlying incurable condition (such as cancer or advanced heart failure), because of the person’s medical history (such as myocardial infarction or stroke), or current clinical condition (such as overwhelming sepsis). If there is a risk of cardiac or respiratory arrest, it is important to make decisions about CPR in advance whenever possible

5.4 There is no ethical or legal requirement to initiate discussion about CPR with patients, or with those close to patients who lack capacity, if the risk of cardiorespiratory arrest is considered low.

5.5 Patients have no legal right to treatment that is clinically inappropriate. If the healthcare team

has good reason to believe that CPR will not re-start the heart and breathing, this should be explained to the patient in a sensitive but unambiguous way. These decisions, and the subsequent discussions informing the patient of the healthcare team’s decision, can be difficult. They should be undertaken by clinicians with the relevant training and expertise, both in assessing the likely outcome and appropriateness of CPR, and with the relevant communication skills. If the patient does not accept the decision a second opinion should be offered, whenever possible. Similarly, if those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation, a second opinion should be offered

##  6.0 COMMUNICATION AND DISCUSSION WITH PATIENTS WITH CAPACITY

6.1 People with capacity should be given opportunities to talk about CPR, but information and discussion should not be forced on unwilling patients. If people indicate that they do not wish to discuss CPR this should be respected and documented. If a best-interests decision about CPR is made by the healthcare team because the patient declined discussion about CPR or asked the healthcare team to make a decision for them, this must be documented in the health record, together with the basis for the decision

##  7.0 REFUSAL OF CPR BY ADULTS WITH CAPACITY

7.1 Adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where healthcare teams believe that CPR may be successful in re-starting a person’s heart and breathing for a sustained period, discussion should ta e place with that person to determine their views and wishes regarding CPR. If people decide that they do not wish to have CPR attempted, this should be documented clearly in their health records

##  8.0 COMMUNICATING AND DISCUSSION WITH PATIENTS WHO DO NOT HAVE CAPACITY

8.1 If a person lacks capacity, any previously expressed wishes should be considered when making a CPR decision, bearing in mind that in some cases those wishes may relate to circumstances that differ substantially from the present situation, or from the circumstances of a future cardiorespiratory arrest Whether the benefit would outweigh the harms and burdens for a particular patient should be the subject of discussion and agreement between the healthcare team and those close to or representing the patient.

8.2 Relevant information should be shared with those close to patients unless, when they were previously competent to do so, a patient has expressed a wish that information be withheld.

##  8.2 *The Law*

8.2.1 Consulting with those close to patients in these circumstances is not only good practice buts also a requirement of the Human Rights Act (Articles 8 – right to private and family life and 10

– right to impart and receive information), and is ordinarily a requirement of the Mental Capacity Act 2005 (England and Wales), and the Adults with Incapacity (Scotland) Act 2000 (see section 10). And the NHS Constitution for England states that people have a right to be involved in their health and Care.

## 9.0 DNACPR DECISIONS WHERE CPR WILL NOT BE SUCCESSFUL AND PATIENTS LACK CAPACITY

9.1 If the person lacks capacity and has appointed a welfare attorney whose authority extends to making decisions of this nature on their behalf, or if a court has appointed a deputy or guardian with similar authority to act on the individual’s behalf, this attorney, deputy or guardian should be informed of the decision and the reason for it (see section 10). If the welfare attorney does not accept the decision, a second opinion should be offered, whenever possible.

## 10.0 INITIAL PRESUMPTION IN FAVOUR OF CPR WHEN THERE IS NO RECORDED CPR DECISION

10.1 If no explicit decision has been made in advance about CPR and the express wishes of a person are unknown and cannot be ascertained, there should be an initial presumption that healthcare professionals will make all reasonable efforts to resuscitate the person in the event of cardiac or respiratory arrest.

10.2 In such emergencies there will rarely be time to make a comprehensive assessment of the person’s condition and the likely outcome of CPR. In these circumstances initiating CPR will usually be appropriate, whilst all possible efforts are made to obtain more information that may guide further decision making. Healthcare provider organisations and healthcare professionals should support anyone initiating and delivering CPR in such circumstances

## 11.0 CHILDREN AND YOUNG PEOPLE UNDER 18 YEARS OF AGE

11.1 Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, parents and the healthcare team. As with adults, decisions about CPR must be made on the basis of an individual assessment of each child or young person’s current situation. It is not necessary to initiate discussion about CPR.

## 12.0 AFTER THE DECISION IS MADE

12.1 The consultant/GP in charge of a patient's care must ensure that any decision reached is effectively communicated to other members of staff, including ambulance personnel and the appropriate hospital doctor should the patient be admitted to a general hospital.

12.2 It should be made clear that a DNACPR decision applies solely to CPR. All other appropriate treatment and care are not to be precluded or influenced by the DNACPR decision

12.3 When the basis for a DNACPR decision is the absence of any likely medical benefit, discussion with the patient, or others close to them should aim at securing an understanding and acceptance of the clinical decision that has been reached. Where relatives, carers etc. disagree with a DNACPR decision, and further discussion has not secured an agreement, a second opinion should be sought from another consultant.

12.4 Information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team. In considering this, clinicians should take account of the fact that people are legally entitled to see and have a copy of their health records.

## 13.0 DOCUMENTING THE DNACPR DECISION

13.1 Packs of DNACPR forms have been issued to all older adults teams . Further copies can be ordered from “clairs”

Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions is an essential part of high quality care. This requires documentation in the health record of detail beyond the content of a specific CPR decision form.

13.2 A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision making in the event of a patient’s cardiorespiratory arrest or death. The final decision regarding whether or not to attempt CPR rests with the healthcare professionals responsible for the patient’s immediate care.

13.3 Paper forms on which CPR decisions are recorded should travel with the patient whenever possible.

13.4 When a person is at home and has a current CPR decision (in particular a DNACPR decision) they understand and accept they should have with them a CPR decision form recording that situation.

13.5 Each form is available in duplicate or triplicate with non-carbon copies that are a different colour and that have different printed wording to reflect their purpose. Only the original (top) copy can then be identified as a CPR decision record for clinical use, avoiding the potential danger of a copy being used to guide clinical decisions when the original may have been cancelled.

13.6 If CPR decision forms are completed and/or stored electronically:

1. they should contain all the required elements defined in this quality standard; they should be accessible immediately by all the organisations and individuals who may be involved in the person’s care
2. there should be robust arrangements in place to ensure that they remain current and appropriate

## 14.0 CONFIDENTIALITY

14.1 If adults have capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing information with others, including family and friends. It may also be helpful to ask people with capacity who they want, or do not want, to be involved in decision-making if they become incapacitate

14.2 Where people lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to those close to the patient where his is necessary to discuss the patient’s care and is not contrary to the patient’s interests.

14.3 Where there is a welfare attorney, deputy, or guardian involved in the discussions, relevant information should be provided to them to enable them to fulfil their role. Where an IMCA is involved they have a legal right to information, including access to the relevant parts of the patient’s health records, in order to enable them to carry out their statutory role

## Responsibility for decision-making

The overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician responsible for the person’s care as defined explicitly by local policy. This could be a consultant, general Practitioner or (GP) or suitably experienced and competent nurse. He or she should always be prepared to discuss a CPR decision with other healthcare professionals involved

in the person’s care. Wherever possible and appropriate, a decision about CPR should be agreed with the whole healthcare team. Monitoring these guidelines Monitoring and training

DNACPR decision making will be monitored through the DNACPR pro forma. The Assurance department will collate copies of completed forms and monitor compliance. Any issues will be addressed with the relevant care team. All cases will be reviewed annually.

Where a patient with a DNACPR order passes away an incident form will always be completed and a review of that person’s care will include examination of compliance with Trust DNACPR procedures.

**IMPORTANT NOTE:**

This document is only a summary and clinicians should make themselves familiar with the up-to-date guidelines from various professional bodies, including the Resuscitation Council. Including the up-to-date guidance is "Decisions Relating [to](http://www.rcn.org.uk/__data/assets/pdf_file/0004/108337/003206.pdf) Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing 2014.

Adherence to the Mental Capacity Act (2005) is a legal requirement and should always be referred to when considering DNACPR decisions.

**Cardiopulmonary Arrest (CPA)** A cardiopulmonary arrest (CPA) is the sudden and complete loss of cardiac function. Not breathing, no palpable pulse detected or signs of circulation or life.

**Cardiopulmonary Resuscitation (CPR**) Basic airway management, mouth-to-mouth/mask to mouth ventilation and chest compressions.

**~~Do Not Attempt Resuscitation Order (DNAR~~**~~)~~***Now referred to as Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)*** A declaration in the patient’s notes that staff should not attempt BLS / CPR in the event of a CPA.

Appendix 1

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| Following two deaths in the Trust where confusion surrounding the patients' 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) status was identified as an issue, we would like to remind staff of the key points regarding DNACPR:* Where patients are transferred into our Trust with a completed Regional/East of England DNACPR form (Fig1), this will accepted as a valid decision whilst awaiting for an ELFT DNACPR form (Fig2) to be completed.
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| **Fig. 1** |

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| **Fig. 2** |

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| * All patients transferred in with a DNACPR should have this decision reviewed by the most senior clinician responsible for the person’s care as soon as possible, ideally within 72hrs. An ELFT DNACPR form will need to be completed.
* Decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person’s condition or in their expressed wishes, or following transfer of the patient to a different location (including transfer within a healthcare establishment).
* Any decision about whether or not to attempt CPR must be recorded clearly in the patient’s current health record and should be available immediately and easily to all healthcare professionals. It is recommended that active DNACPR decisions are discussed at every hand-over meeting to ensure all staff are aware of the patient’s current status.
* If all active DNACPR forms are discussed/viewed during handovers then it will be appropriate not to start CPR in the event of a cardiac/respiratory arrest as staff will have seen the form that shift. However, if staff have not seen the active DNACPR form that shift, then they should start CPR until the form is brought to them for inspection and confirmation before stopping CPR.
* Any decision about CPR should be communicated clearly to all those involved in the patient’s care.
* A DNACPR decision does not override clinical judgement in the unlikely event of the patient’s cardiac arrest being due to a reversible cause that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include but are not restricted to – choking, or a blocked tracheostomy tube. In these situations, CPR would be appropriate.
* If no explicit decision has been recorded in advance about CPR, if there is any doubt as to the existence of a completed DNACPR form, or the express wishes of a person are unknown and cannot be ascertained, staff will make all reasonable efforts to resuscitate the person in the event of cardiac or respiratory arrest.
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