

# NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Policy for Adults



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## 1. Introduction

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The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, then that treatment is no longer justified (BMA, RC (UK) RCN 2007).

Survival following cardiopulmonary resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Whilst patients who have an acute event, such as a myocardial infarction, may recover with CPR, the chances of survival are much lower for patients who have a cardiopulmonary arrest due to progression of a life limiting condition. 80% of cardiac arrests occur outside hospital and 90% of these will result in death. When cardiac arrest occurs in hospital, 13-17% survive to hospital discharge and many of these will have long term disability.

Cardiopulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically CPR could be used on every individual prior to death. It is therefore essential to identify patients for whom cardiopulmonary arrest represents the terminal event in their illness and for whom CPR is inappropriate. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to ensure that if death occurs there is no added loss of dignity. It is also essential to identify those patients who would not want CPR to be attempted in the event of a cardio-respiratory arrest and who competently refuse this treatment option.

## 2. Policy Statement

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- 2.1 This policy is intended to prevent inappropriate, futile and / or unwanted attempts at cardiopulmonary resuscitation (CPR) for adult patients (aged over 16 years) in all care settings across the east of England. It does not refer to other aspects of care, for example, analgesia, antibiotics, suction, treatment of choking, treatment of anaphylaxis or other interventions which are sometimes loosely referred to as "resuscitation".
- 2.2 Variations in local policies can cause misunderstandings and lead to distressing incidents for patients, families and staff. Increased movement of patients and staff between different care settings makes a single, integrated and consistent approach to this complex and crucial area a necessity.

- 2.3 The Integrated East of England DNACPR policy will ensure the following:
- 2.3.1 All people are initially presumed to be for cardiopulmonary resuscitation unless a valid DNACPR decision or a valid Advance Decision to Refuse Treatment (ADRT), refusing cardiopulmonary resuscitation, has been made and documented.
  - 2.3.2 All DNACPR decisions are based on current legislation and guidance.
  - 2.3.3 When CPR would not restart the heart and breathing of the individual it will not be attempted. In these circumstances, there is no obligation to explore an individual's wishes around CPR, though it could form part of a sensitive discussion about the progression of a life limiting illness and end of life care planning.
  - 2.3.4 When CPR might restart the heart and breathing of the individual discussion will take place with that individual if this is possible, (or with other appropriate individuals for people without capacity) to clarify their wishes, although people have a right to refuse to have these discussions.
  - 2.3.5 A standardised documentation form for adult DNACPR decisions will be used (see appendix 1).
  - 2.3.6 Effective communication concerning the individual's resuscitation status will occur between all members of the multidisciplinary healthcare team involved in their care and across the range of care settings.
  - 2.3.7 The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.
  - 2.3.8 Training will be available to enable staff to meet the requirements of this policy.

### **3. Purpose**

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- 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
  - both of which will inform whether the benefits of attempting CPR outweigh any burdens.

- 3.2 This policy will provide clear guidance for clinical 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 option
- 3.4 This policy will help inform end of life care advance care planning for patients with a progressive life limiting illness.

#### **4. Scope**

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- 4.1 This policy applies to all of the multidisciplinary healthcare team involved in a patient's care across the range of settings within the NHS East of England.
- 4.2 This policy can be applied to all individuals over the age of 16 years.

#### **5. Legislation and Guidance**

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##### **5.1 Legislation**

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- 5.1.1 Under the Mental Capacity Act (2005) clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made
- 5.1.2 The following sections of the Human Rights Act (1998) are 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).
- 5.1.3 An Equality Impact Assessment (EIA) has been carried out by NHS East of England.

## 5.2 Guidance

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5.2.1 Guidance has been developed by the Resuscitation Council (UK):

- recommending standards for recording “Do not attempt resuscitation” (DNAR) decisions (2009)
- 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, update 3rd edition October 2014).

Decisions Relating to Cardiopulmonary Resuscitation  
[www.resus.org.uk/pages/dnar.pdf](http://www.resus.org.uk/pages/dnar.pdf)

## 6. Roles and Responsibilities

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- 6.1 This policy and its forms / appendices are relevant to all clinical staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed by the local authority or employed privately by an agency.
- 6.2 The decision to complete a DNACPR form should be made by the most senior clinician in charge of the patient's care. This may be a Consultant (or another Doctor, or Specialty Trainee ST3 or above, who has been delegated the responsibility by their employer), General Practitioner or a suitably experienced senior nurse, for example, Nurse Consultant, with appropriate accreditation from their employing organisation.
- 6.3 Patients who have made a decision that they would not want CPR should inform, where able, those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.
- 6.4 NHS East of England (or an appropriate successor organisation once the SHA has disbanded) is responsible for:
- ensuring that this policy adheres to statutory requirements and professional guidance
  - supporting unified policy development and the implementation for other organisations
  - ensuring that the policy is monitored
  - reviewing of policy every two years.

- 6.5 Chief Executives of provider organisations are responsible for:
- governance compliance for the policy and procedure
  - procuring and / or providing legal support.
- 6.6 Directors or Managers responsible for the delivery of care must ensure that:
- staff are aware of the policy and how to access it
  - the policy is implemented
  - staff understand the importance of issues regarding DNACPR
  - staff are trained and updated in managing DNACPR decisions
  - the policy is audited and the audit details are fed back to their commissioning organisation
  - ensure that DNACPR forms, patient leaflets and policy are available as required.
- 6.7 Consultants, General Practitioners and appropriately trained senior nurses are responsible for making DNACPR decisions. They must:
- be competent to make the decision
  - must verify any decisions made by junior medical staff / other accredited healthcare professionals at the earliest opportunity
  - document the decision (see 7.8)
  - make every effort to provide the patient with information, involve the individual in the decision, and if appropriate involve relevant others in the making of the decision.
  - communicate the decision to other healthcare providers
  - review the decision if necessary.
- 6.8 Clinical staff delivering care must:
- adhere to the policy and procedure
  - notify their line manager of any training needs
  - sensitively enquire to the existence of a DNACPR or a ADRT
  - check the validity of any documentation
  - notify other services of the DNACPR decision or an ADRT on the transfer of a person
  - participate in the audit process.

- 6.9 Commissioners and Commissioned Services must:
- ensure that services commissioned implement and adhere to the policy and procedure
  - ensure that pharmacists, dentists and others in similar healthcare occupations are aware of this policy.
- 6.10 The Ambulance service staff must:
- adhere to the policy and procedure
  - notify their line manager of any training needs
  - ensure that they are aware of the existence of a DNACPR decision or an ADRT, either via the individual / relatives or the health care professional requesting assistance
  - check the validity of any decision
  - participate in the audit process.

## **7. Procedure**

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- 7.1 For the majority of people receiving care in a hospital or community setting, the likelihood of cardiopulmonary arrest is small; therefore, no discussion of such an event routinely occurs unless raised by the individual.
- 7.2 In the event of an unexpected cardiac arrest every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council (UK) unless a valid DNACPR decision or an ADRT is in place and made known.
- 7.3 In the event of a clinician finding a person dead and where there is no DNACPR decision or an ADRT to refuse CPR, the clinician must rapidly assess the case as to whether it is appropriate to commence CPR. Providing the clinician has demonstrated a rational process in decision making, the employing organisation will support the member of staff if this decision is challenged. Consideration of the following will help to form a decision, but it must be stressed that professional judgement that can be justified and later documented must be exercised.



- what is the likely expected outcome of undertaking CPR? For example, it would be inappropriate to start CPR if it will not re-start the heart and maintain breathing
- what is the balance between the right to life and the right to be free from inhuman and degrading treatment? Human Rights Act 1998.

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

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

7.5. The summary decision-making framework is illustrated in 8.0. When considering making a DNACPR decision for an individual it is important to consider the following:

- is a cardiac or respiratory arrest a clear possibility for this individual? If not it may not be necessary to go any further
- if a cardiac or respiratory arrest is a clear possibility for the individual, and CPR maybe successful, will it be followed by a length and quality of life that would not be of overall benefit to the person? The person's views and wishes in this situation are essential and should be respected
- if the individual is in the terminal stage of a progressive life limiting illness, where death is unavoidable, they should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual.

7.6. Responsibility for decision making needs to take into account a number of factors:

- A competent patient can:
  - Make an advance refusal of CPR
  - Accept (consent to) CPR if offered
- A patient who has capacity has no legal right to demand CPR (or any other medical treatment) if the responsible senior clinician and multi-professional healthcare team judge that it would not be medically successful in achieving sustainable life.

- Family / carers of a patient who has capacity should not be involved in resuscitation discussions without that patient's consent.
- Where a patient lacks capacity for involvement in advance decisions and has no legally appointed lasting power of attorney (LPA) for health and welfare or Court Appointed Deputy (CAD) the responsibility for deciding if resuscitation is in the patient's best interest lies with the lead clinician with clinical responsibility for the patient. Family / carers do not have decision-making rights or responsibilities in this circumstance. Discussion with the family has the primary aim of trying to clarify the patient's views, prior to incapacity, and forms part of the best interests decision process.
- Where a patient lacks capacity and has no family, friends or other advocate to speak on their behalf, the Mental Capacity Act 2005 requires consultation with an independent mental capacity advocate (IMCA) regarding all decisions made by an NHS body or Local Authority about 'serious medical treatment'. Where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a decision about CPR is being considered on the balance of benefits and risks, in order to comply with the law an IMCA must be involved in every case. If a CPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and the reasons for it should be recorded in the health record and an IMCA should be consulted at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician responsible for the person's care as part of the determination.
- Where a patient lacks capacity for involvement in advance decisions and a legally appointed lasting power of attorney for health and welfare or CAD has been identified
- The proxy decision maker can:
  - make an advance refusal of CPR for the patient
  - accept (consent to) CPR if offered (and judged by the responsible senior clinician and multi-disciplinary healthcare team to be likely to achieve sustainable life for the patient).
- The proxy decision maker cannot:
  - demand CPR (or any other medical treatment) if the responsible senior clinician and multi-professional healthcare team judge that it would not be medically successful in achieving sustainable life.

7.7 If a DNACPR discussion and decision is deemed appropriate the following need to be considered:

- It is rarely appropriate to discuss DNACPR decisions in isolation from other aspects of end of life care. DNACPR is only one small aspect of advance care planning which can help patients achieve their wishes for their end of life care.

- The patient should be given as much information as they wish about their situation, including information about CPR in the context of their own illness and sensitive communication around dying and end of life issues.
- A Cardiopulmonary Resuscitation patient information leaflet (for example the NHS East of England leaflet - see Appendix 2) should be made available, where appropriate to individuals and their relatives or carers. It is the responsibility of the individual organisation to ensure that different formats and languages can be made available.
- Where a DNACPR decision is made on medical grounds because CPR will fail, there should be a presumption in favour of informing the patient of the decision and explaining the reason for it unless that would cause them severe distress.

#### 7.8 Documenting and communicating the decision

- Once the decision has been made it must be recorded on the SHA approved Adult form (see appendix 1) and written in the person's notes.
- Additional information regarding the background to the decision, the reasons for the decision, those involved in the decision and a full explanation of the process must be recorded in the individual's notes / care records / care plans.
- if a DNACPR decision is made and there has been no discussion with the individual the reasons for this must be documented in the person's notes.

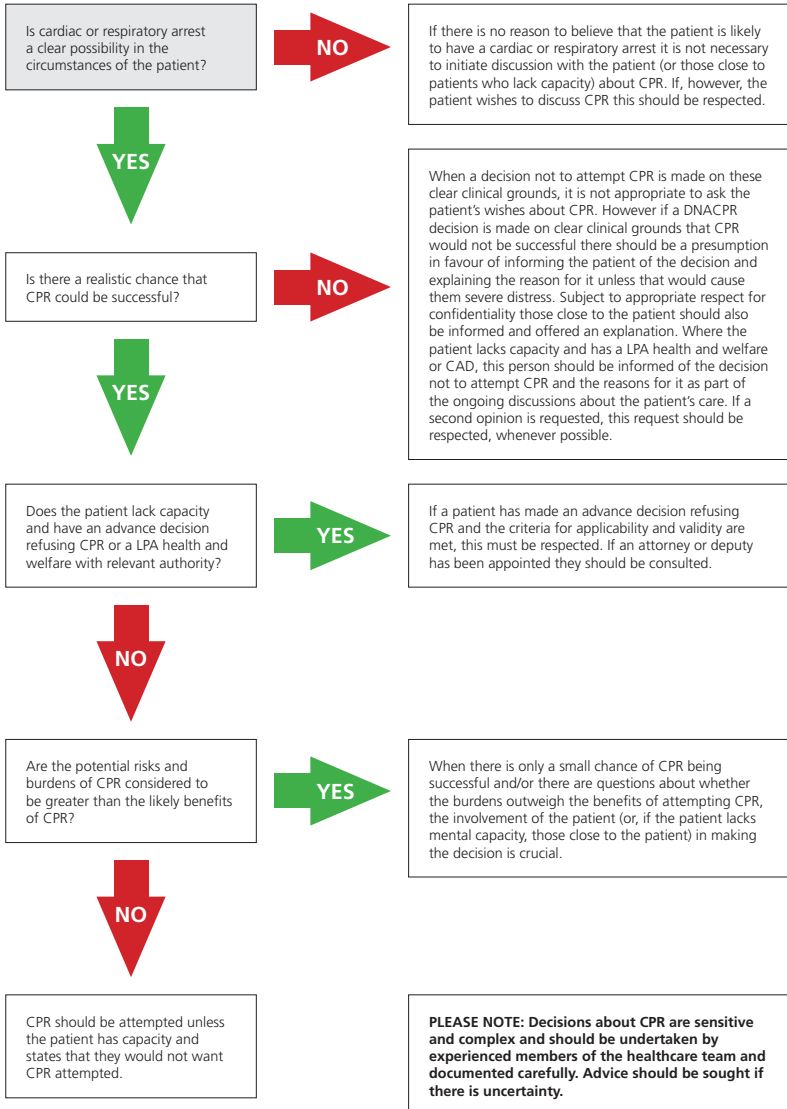
7.9 The form will stay with the patient, and should be kept in a prominent position in the medical notes in inpatient settings or in the district nursing notes in the community. The original form should be returned to the patient on discharge from the inpatient care setting.

7.10 GP surgeries should ensure that the DNACPR decision is recorded in the individual's electronic problem list using the appropriate code or included in the "End of Life Care" section of the Summary Care Record where this is in use. The relevant information should also be shared with GP out of hour's services and ambulance call centres using the appropriate local mechanism.

7.11 During ambulance transfer between healthcare settings and home, the form should go with the patient and ambulance service staff should abide by the DNACPR decision. Where the facility exists, and the patient gives consent, the DNACPR status should be recorded on ambulance service databases.

- 7.12 Following transfer between healthcare settings, DNACPR decisions remain valid but should be verified as soon as possible by the clinician with overall responsibility for the person's care.
- 7.13 Confidentiality - If the individual has the mental capacity to make decisions about how their clinical information is shared their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity and their views on involving family and friends are not known, clinicians may disclose confidential information to people close to them where this is necessary to discuss the individual's care and is not contrary to the individual's interests.

## 8 Summary Decision Making Framework



## 9 **Review**

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9.1 This decision will be regarded as 'Indefinite' unless:

- a definite review date is specified.
- there are relevant changes in the person's condition.
- their expressed wishes change.

The frequency of review should be determined by the responsible senior clinician in charge of the individual's care at the time of the initial decision.

9.2 It is important to note that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR decision is reviewed, the clinician must consider whether the person can contribute to the decision making process each time. It is not usually necessary to discuss CPR with the person each time the decision is reviewed if they were involved in the initial decision, although where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

## 10 **Situations where there is lack of agreement**

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10.1. A person with mental capacity may refuse any treatment from a doctor or nurse even if that refusal results in death and any treatment carried out against their wishes is technically an assault. In these circumstances, Individuals should be encouraged to make an ADRT.

10.1.1 Should the person refuse CPR, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual and possibly their relatives, has taken place.

10.1.2 A verbal request to decline CPR is not legally binding; however it should not be ignored and does need to be taken into account when making a best interest decision. The verbal request needs to be documented by the person who it is directed to and any decision to take actions contrary to it must be robust, accounted for and documented.

- 10.2 Individuals may insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Sensitive discussion with the person should aim to secure their understanding and acceptance of the DNACPR decision. Ongoing patient education, a period of time for reflection and opportunities for discussion will often result in agreement.
- 10.2.1 Although individuals do not have a legal right to demand that doctors carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected wherever possible.
- 10.2.2 In the case of disagreement a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought.

## **11 Cancellation of a DNACPR Decision**

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- 11.1 If the person's clinical condition changes, the 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 ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional.
- 11.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision. Electronic versions of the DNACPR decision must be cancelled as per guidance above.

## **12 Suspension of DNACPR Decision**

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- 12.1 In some circumstances there are reversible causes of a cardio-respiratory arrest these are either pre-planned or acute and the individual should receive treatment, unless intervention in these circumstances has been specified.
- 12.1.1 Pre-planned: Some procedures could precipitate a cardiopulmonary arrest for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc; under these circumstances the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people including the person, if appropriate, will need to take place.

- 12.1.2 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.

## **13 Clinical Governance**

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- 13.1 All organisations will have clear governance arrangements in place which indicate individuals and committees who are responsible for the governance of this policy at a local level.
- 13.2 All organisations within NHS East of England are encouraged to undertake an annual audit of DNACPR decision-making and documentation.
- 13.3 Information collated from local audits should be used for future planning, identification of training needs and for policy review.

## **14 Definitions**

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- 14.1 **Cardio Pulmonary Resuscitation (CPR)** Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.
- 14.2 **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.
- 14.3 **Mental Capacity Act - 2005 (MCA)** was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.



- 14.4 **Mental Capacity** - An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals that lack capacity will not be able to:
- understand the information relevant to the decision
  - retain that information
  - use or weigh that information as part of the process of making the decision
  - communicate the decision, whether by talking or sign language or by any other means.
- 14.5 **Advance Decision to Refuse Treatment (ADRT)** a decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.
- 14.6 **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 / treatment / care such as fluid replacement, feeding, antibiotics etc.
- 14.7 **Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA).** The Mental Capacity Act (2005) allows people over the age of 18 years of age, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and wellbeing on their behalf, once capacity is lost.
- 14.8 **Independent Mental Capacity Advocate (IMCA).** An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them.
- 14.9 **A Court-appointed deputy (CAD)** 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
- 14.10 **Advance Care Plan.** A plan which allows the individual to express and record wishes about future care in the final months of life.

## 15 References

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Advance Decision to Refuse Treatment, a guide for health and social care professionals. London: Department of health [Accessed 14.08.10].

BRITISH MEDICAL ASSOCIATION, (2000). The impact of the Human Rights Act 1998 on medical decision-making. London, BMA Books.

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GMC Treatment and Care Towards the end of life: good practice in decision making 2010

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Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy NHS South Central 2010

# Policy Appendices

# Appendix 1: Unified DNACPR Form

## DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.



**East of England**

**DO NOT PHOTOCOPY**

**ORIGINAL  
PATIENT COPY TO  
STAY WITH PATIENT**

**Date of DNACPR order:**

<b>Name:</b>				(OR USE ADDRESSOGRAPH)
<b>Address:</b>				
	<b>Postcode:</b>			
<b>NHS number:</b>		<b>Date of birth:</b>		

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### REASON FOR DNACPR DECISION (tick one or more boxes and provide further information)

CPR is unlikely to be successful (i.e. medically futile) because:

\_\_\_\_\_

Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

\_\_\_\_\_

Patient does not want to be resuscitated as evidenced by:

\_\_\_\_\_

### RECORD OF DISCUSSION OF DECISION (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)? Yes  No   
If 'yes' record content of discussion. If 'no' say why not discussed.

\_\_\_\_\_

Discussed with relatives / carers / others? Yes  No   
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

\_\_\_\_\_

Discussed with other members of the health care team? Yes  No   
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

\_\_\_\_\_

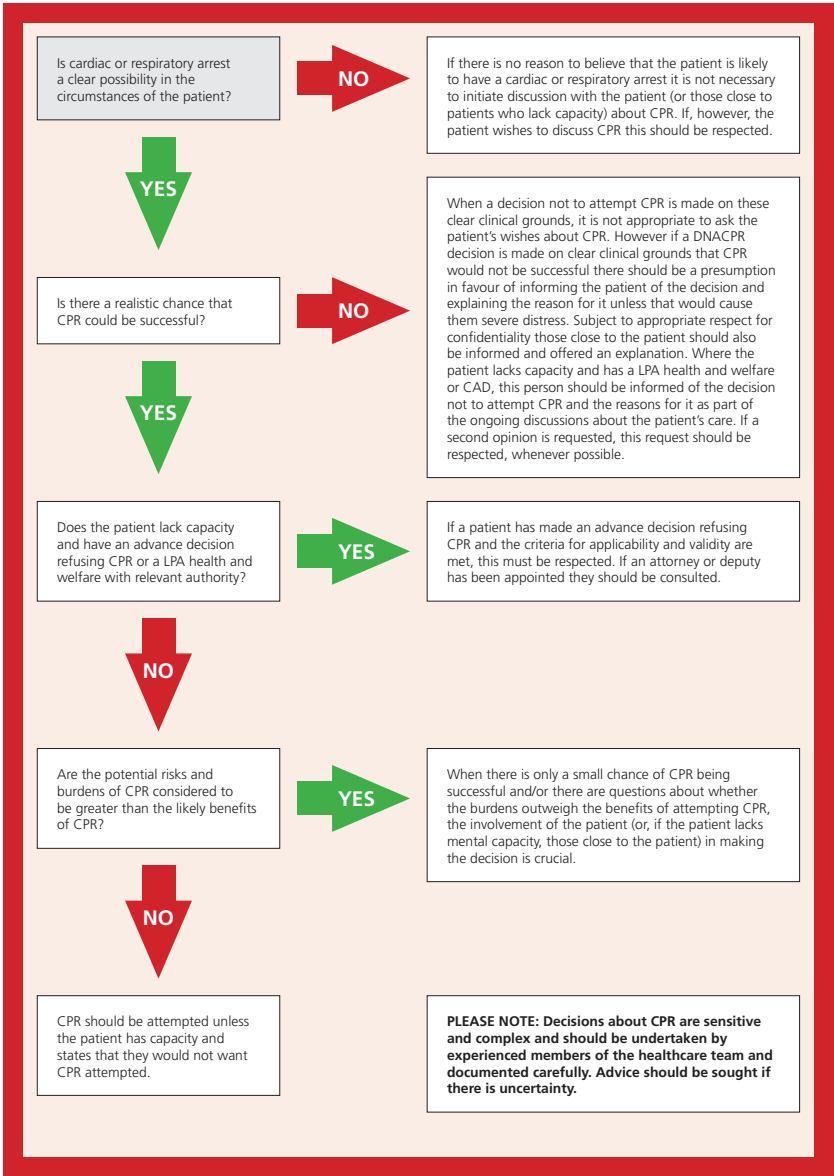
Is DNACPR decision indefinite? Yes  No  If 'no' specify review date: \_\_\_\_\_

### HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER

<b>Name:</b>		<b>Signature:</b>		
<b>Position:</b>		<b>Date:</b>		<b>Time:</b>

### REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN

<b>Name:</b>		<b>Signature:</b>		
<b>Position:</b>		<b>Date:</b>		<b>Time:</b>



## Appendix 2: DNACPR Patient Information Leaflet



# Cardiopulmonary Resuscitation (CPR)

## Patient Information Leaflet

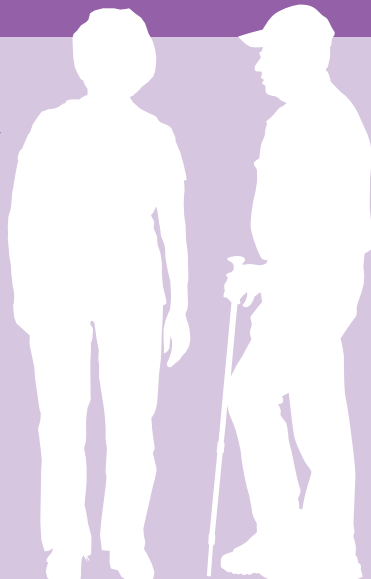
### **This leaflet explains:**

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- What cardiopulmonary resuscitation (CPR) is
- How decisions about CPR are made
- How you can be involved in deciding whether you receive CPR

This is a general leaflet for patients over 16 years old. It may also be useful to relatives, friends and carers of patients. This leaflet may not answer all your questions about CPR but it should help you think about the issues and choices available.

If you have any other questions, please talk to one of the health professionals caring for you.



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- How decisions about CPR are made
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If you have any other questions, please talk to one of the health professionals caring for you.

## 1. What is CPR?

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

CPR can include:

- repeatedly pushing down very firmly on the chest
- using electric shocks to try to restart the heart
- 'mouth-to-mouth' breathing; and
- artificially inflating the lungs through a mask over the nose and mouth or a tube inserted into the windpipe.

## 2. When is CPR used?

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CPR is most often used in emergency situations, for example if you have a serious injury or suffer a heart attack. However, CPR is not always automatically used; this depends on the circumstances and the doctor's estimate of how likely it is to work.

If you are already very seriously ill and nearing the end of life, there may be no benefit in trying to revive you. In this case, CPR may not be attempted.

CPR will not be used if you have said in advance that you do not wish to receive it. The information in this leaflet has been written to help you to decide whether or not you want to make this decision. It is important to remember that your relatives, friends or carers cannot make this decision for you.

## 3. Does CPR always work?

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The chances of CPR restarting your heart and breathing will depend on:

- why your heart and breathing have stopped
- any illness or medical problems you have (or have had in the past)
- the overall condition of your health.

When CPR is attempted in a hospital it is successful in restarting the heart and breathing in about 4 out of 10 patients. However only about 2 out of 10 patients survive long enough to leave hospital.

The figures are much lower for patients with serious underlying conditions and for those not in hospital.

It is important to remember that these figures only give a general picture and not a definite prediction of what you personally can expect. Everybody is different and your healthcare team will explain how CPR might affect you.

#### **4. Can CPR ever be harmful?**

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The techniques used to start your heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs. Attempts at CPR do not always restart the heart and breathing despite the best efforts of all concerned. Success depends on why your heart and breathing stopped, and on your general health. It also depends on how quickly your heart and breathing can be restarted.

People who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some patients make a full recovery; some recover but have health problems. Some people never get back the level of physical or mental health they previously enjoyed.

Some have brain damage or go into a coma. People with many medical problems are less likely to make a full recovery.

#### **5. Can I decide in advance that I DON'T want to have CPR if my heart or breathing stops?**

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If you know that you do not want CPR, you can inform your doctor, who will ensure that your decision is respected. You may also find it useful to make a living will (also known as an Advance Decision) to document your wishes. If you have a living will, you should let your healthcare team know about it so they can keep a copy of it in your healthcare records. You should also let the people close to you know so they are aware of your wishes.

For more information on Advance Decisions visit:

[www.adrtnhs.co.uk](http://www.adrtnhs.co.uk)

#### **6. Can I decide in advance that I DO want to have CPR if my heart or breathing stops?**

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If you think you would like to have CPR, then it is a good idea to discuss this with your doctor and make sure that they know your views. However, CPR will only be given if the doctor believes it is clinically appropriate. This will depend



on your current state of health and other underlying medical problems. Your doctor can explain the chances of CPR being effective in your case.

If there is a chance that CPR could restart your heart and breathing but it is likely to leave you severely ill or disabled, your opinion about whether these chances are worth taking are very important. Your doctor will listen to your opinions and, if you choose to involve them, the opinions of your family, carers and friends.

If you disagree with your doctors opinion about whether CPR is appropriate for you, you can ask for a second opinion. You can also seek mediation or counselling or use the formal complaints procedure.

## **7. If I make a decision about CPR can I change my mind later?**

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### **Patients who previously wished to receive CPR**

You can change your mind at any time. If you have changed your mind, you should inform a member of staff who will ensure a doctor is contacted to discuss the decision with you. Your doctor will make sure that your most recent decision is documented in your healthcare record. If you have changed your mind since making an Advance Decision, the staff caring for you will dispose of the old documentation.

### **Patients who previously wished not to receive CPR**

If you have changed your mind, and now DO wish to receive CPR, you should discuss this with your doctor and document it in writing. Also, see point 5 above: a patient's decision to receive CPR will only be carried out if the health team believes it is appropriate.

## **8. Do I have to make a decision about whether or not I want to receive CPR in the future?**

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You don't have to make a decision about CPR at all if you don't want to. Alternatively, you can think about it at a later stage if you feel you are not sure at the moment. Your family, close friends, carers or those who you feel know you best might be able to help you make a decision you are comfortable with.

If you have not made any decision about CPR, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you have said and their own judgement.

## 9. What if I am unable to decide for myself?

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The law allows you to appoint someone to make decisions for you. This can be a friend, relative, or anyone whom you trust. This person will be consulted if at a later date you lose the ability to make decisions for yourself.

This person is known as your Lasting Power of Attorney (LPA). To appoint an LPA, you should speak to an Independent Mental Capacity Advocate (IMCA) or another impartial person such as a solicitor who will be able to advise you on appointing a suitable LPA.

If you have not formally appointed an LPA, the doctor in charge of your care will make a decision about what is best for you, taking into account the views of your family and friends. If there are people you do, or do not want to be asked about your care, you should let the healthcare team know.

## 10. If I or my doctor decide I shouldn't have CPR, will this have an effect on other treatment?

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Your doctors and nurses will continue to give you the best possible treatment and care. Your doctor will make sure that you, the healthcare team, and friends and family involved know and understand the

decision. A decision not to receive CPR refers only to resuscitation, and you will receive all other treatment that you need.

## 11. Who else can I talk to about this?

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If you need to talk about this with someone outside of your family, friends or carers, to help you decide what you want, you may find it helpful to contact any of the following:

- Counsellors
- Independent Advocacy Services
- Patient Advice and Liaison Service (PALS)
- Patient support services
- Spiritual carers, such as a chaplain.

If you feel you have not had the chance to have a proper discussion with your care team, or you are not happy with the discussions you have had, you can follow the formal complaints procedure. Please do not hesitate to keep asking questions until you understand all that you wish to know.

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Victoria House, Capital Park, Fulbourn, Cambridge CB21 5XB  
Tel: 01223 597 500 Fax: 01223 597 555  
[www.eoe.nhs.uk](http://www.eoe.nhs.uk)

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