Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy (incorporating Lincolnshire Unified Principles for Adult Do Not Attempt Cardiopulmonary Resuscitation)

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Lincolnshire Community Health Services NHS Trust
Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
Version Control Sheet

Version	Section/Para/Appendix	Version/Description of Amendments	Date	Author/ Amended by
1	2.0	Moved from 9.0	17.0.8.10	J Anderson
	Fig 1	Moved from Appendix 2	17.08.10	J Anderson
	Fig 2	Added	17.08.10	J Anderson
2	Title	Change to reflect regional unified principles of DNACPR	28.12.11	J Anderson
	Statement	To reflect policy applies to >18yr olds	28.12.11	J Anderson
	Whole policy	DNACPR added to text	4.1.12	J Anderson
	Fig.2	Senior Clinician with delegated responsibility added. Time frame of 4 hours removed	4.1.12	J Anderson
	10.1	GP within community setting added to wording	4.1.12	J Anderson
	10.1.3	Wording changed to reflect the Unified principles.	4.1.12	J Anderson
	13.2	Wording changed to state that the form should remain with the patient.	4.1.12	J Anderson
	15.2	Systm one added	4.1.12	J Anderson
	19.3	IR1 changed to Datix	4.1.12	J Anderson
	18	Evidence base added to	4.1.12	J Anderson
	20.2	Further training statement added	4.1.12	J Anderson
	Appendix 4	EMAS form removed from policy	4.1.12	J Anderson
	Appendix 4 (5 previously)	Reference add	4.1.12	J Anderson
3	Appendix 2	Patient Information Leaflet removed and alternative added	2.11.12	J Anderson
	13.3	Scanning of form added	2.11.12	J Anderson
4		Full policy review	July 2014	J Anderson
5		Full policy review to change name and incorporate Unified Lincolnshire Principles.	July 2016	T Balderstone

Policy statement

Background	This policy details the standards and considerations across Lincolnshire Community Health Services NHS Trust, relating to cardiopulmonary resuscitation decisions for patients.
Statement	This policy outlines the legal and ethical standards for planning patient care and decision making in relation to cardiopulmonary resuscitation. It is the intention of Lincolnshire Community Health Services that this policy ensures that all healthcare professionals are aware of the legal and ethical issues regarding cardiopulmonary resuscitation and are enabled to adopt practices which aim to ensure the understanding and support of the patient and thus minimise the risk of legal challenge. This policy should be applied to patients over the age of 16 years (with specific guidance for children and young people referenced in Appendix 4) on the basis of clinical need alone.
Responsibilities	Compliance with the policy will be the responsibility of all Lincolnshire Community Health Services NHS Trust
Trainers	Directors/Heads of Service will be responsible for ensuring that all appropriate staff have training in line with the policy
Resource implication	The policy has been developed in line with the Lincolnshire NHS Unified Principles for Adult Do Not Attempt Cardiopulmonary Resuscitation working group and adopted by all organisations detailed within the signature table. LCHS will follow the principals contained within this plocy as an element of that agreement.

Lincolnshire Community Health Services

Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
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Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

1. Introduction

1.1 This policy details the standards, considerations and procedures within Lincolnshire Community Health Services, relating to cardiopulmonary resuscitation decisions for patients.

1.2 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).

1.3 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. Eighty percent 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.

1.4 Cardiopulmonary resuscitation 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 cardiorespiratory arrest and who competently refuse this treatment option.

2. General Principles

2.1 This policy is intended to prevent inappropriate, futile and/or unwanted attempts at cardiopulmonary resuscitation for adult patients (aged over 16 years) in all care settings across Lincolnshire. 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 This policy applies to all of the multidisciplinary healthcare team involved in the patient’s care.

2.3 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 sensitive area a necessity. Therefore, agreement has been reached across providers to use a single DNACPR form and policy.

2.4 Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

2.5 If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.

2.6 For many people anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

2.7 Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

2.8 If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.

2.9 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.

2.10 For a person in whom CPR may be successful, when a decision about future CPR is being considered there should be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best-interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision-makers.

2.11 If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable Advance Decision Refusing Treatment (ADRT), specifically refusing CPR, this must be respected.

2.12 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. The Court of Appeal in a landmark judgment handed down in relation to Janet Tracey (2014) found that an NHS Trust had a **legal duty** to tell a patient, with mental capacity, that a Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) order had been placed on her medical records.

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

2.14 Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.

2.15 Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

2.16 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 often requires documentation in the health record of detail beyond the content of a specific CPR decision form.

2.17 A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest 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, a displaced tracheal tube or a blocked tracheostomy tube.

2.18 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.

2.19 Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example 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.

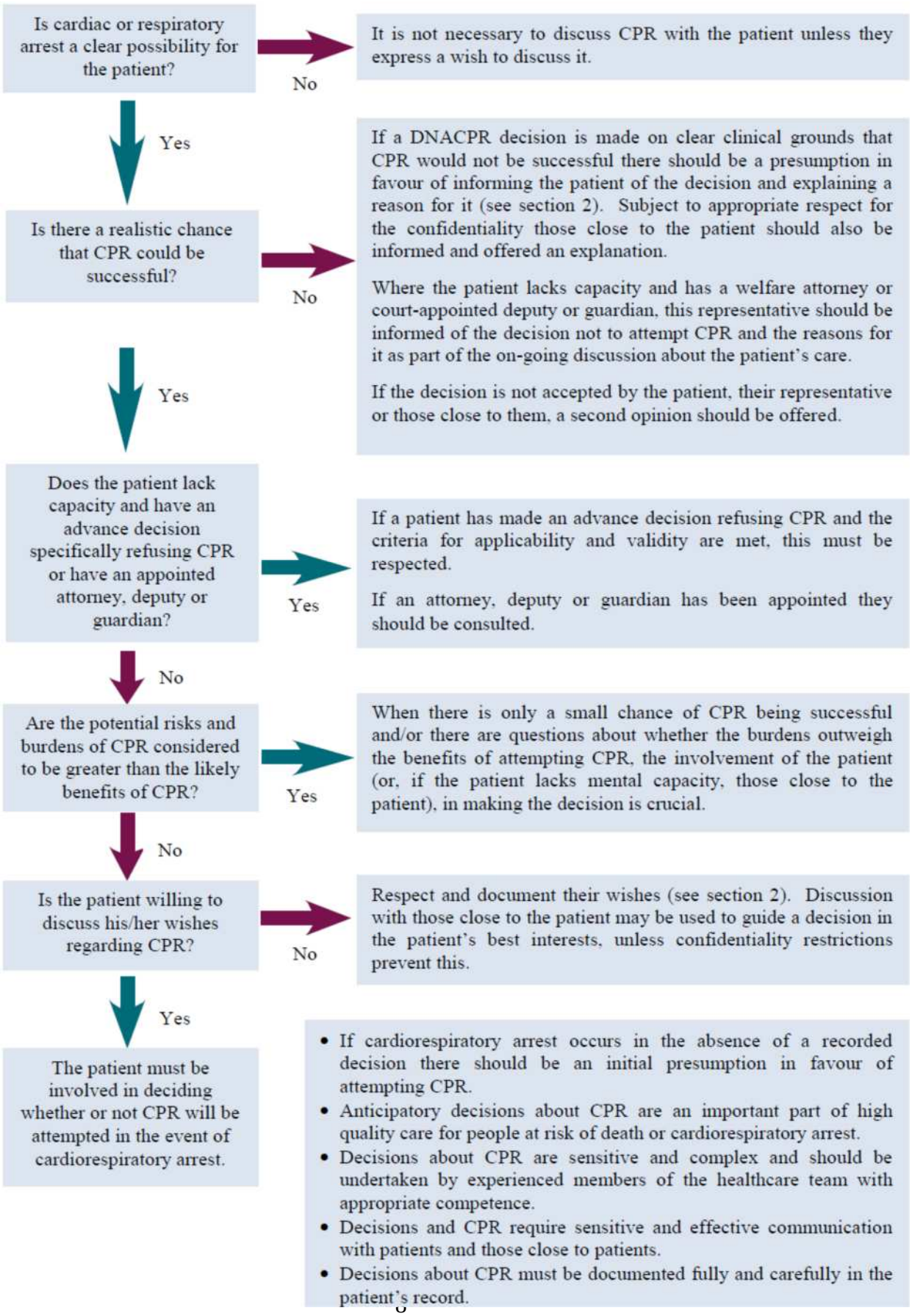
2.20 Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes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

2.21 The original DNACPR form must accompany a patient when they move from one setting to another.

2.22 Organisations signed up to this policy:

Organisation	**Committee signed up to Policy on behalf of Organisation**
BMI -The Lincoln Hospital	
Butterfly Hospice Trust	
East Midlands Ambulance Service	
Lincolnshire Community Health Services	
Lincolnshire County Council (on behalf of commissioning nursing home care)	
Lincolnshire East CCG	
Lincolnshire Medical Committee	
Lincolnshire Nursing Home Association	
Lincolnshire Partnership NHS Foundation Trust	
Lincolnshire West CCG	
Marie Curie Cancer Care	
NSL Ambulance Transport Services	
South Lincolnshire CCG	
South West Lincolnshire CCG	
St Barnabas Hospice Lincolnshire	
United Lincolnshire Hospitals NHS Trust	

3. Decision making framework



4. Legislation & Guidance

a. Legislation

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.

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)
- In addition this policy takes heed of, and is compliant with, the Court of Appeal ruling on DNACPR decisions and the Human Rights Act (June 2014)

b. Guidance

The LCHS Mental Capacity Act (Including Deprivation of Liberty Safeguards) Policy P_CS_42 provides clinicians with details of requirements under the Mental Capacity Act.

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

i. Recommending standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
ii. 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, updated October 2014)
iii. Decisions relating to Cardiopulmonary Resuscitation is available at www.resus.org.uk/pages/decisionsrelatingtoCPR.pdf

5. Procedure

5.1 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.

5.2 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.

5.3 In the event of a clinician finding a person with no signs of life 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. Professional judgement must be exercised and documented as soon as practically possible after the event. Consideration of the following will help to form a decision:

- 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)?

5.4 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.

5.5 All people are assumed to have capacity unless otherwise stated or they are incapacitated at the time of the decision e.g. unconscious in Urgent Care departments. In emergency situations urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies.

5.6 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. The unified DNACPR form (Appendix 1) should be used and accepted by all providers across Lincolnshire. However, it is possible that a patient may have a DNACPR decision documented on a different form. For example, they may have been transferred from a different county, an old version of the form may have been used in error, or their DNACPR decision may have been documented in an Advance Decision to Refuse Treatment without an accompanying form. Unless there is a good reason to believe the DNACPR decision is not genuine or applicable, it should be accepted as valid until the decision is reviewed by the patient's responsible senior clinician. Similarly, a photocopy of a DNACPR form should be accepted unless there is evidence it should not be considered valid. However, if the original form is not present with the patient, a new form should be completed at the earliest opportunity.

6. Completing the DNACPR Form

6.1 These are the guidelines for completing the Unified DNACPR Form for use across all providers in Lincolnshire, section by section. There are brief guidance notes available on the back of the form.

Box 1 - **Patient details**
Enter the patient's full name, date of birth and NHS number. An addressograph label may be used providing it contains all three identifiers.

Box 2 - **Date of DNACPR decision**
Enter the date that the decision was made. A judgment then needs to be made whether the DNACPR decision will need to be reviewed. A fixed review date is not normally recommended, as this may lead to uncertainty about the validity of the form once the review date has passed, if a review does not take place.

The decision should be regarded as indefinite unless:

- A definite review date is specified. If a date is specified the form will be regarded as invalid after that date unless it has been reviewed.

- There are significant changes in the patient's condition. This will prompt a review of the decision with the patient.

- The patient's wishes change. This will also prompt a review of the decision with the patient.

Box 3 – **Patients preferred place of care**
Discussions with patients about CPR are best undertaken as part of a wider conversation about their understanding around their illness, their treatment and care options and preferences. This would usually include asking about their preferred place of care. This information can be documented in this section, and updated if it changes.

Box 4 - **Reason for DNACPR decision**
Tick one or more boxes to indicate the reason for the DNACPR decision, and provide further information to support the decision.

4 a) CPR is unlikely to be successful
State the underlying condition and reasons why CPR would be unlikely to succeed. Where a patient is likely to die naturally because of an irreversible condition, CPR would not be successful and should not be attempted. In these circumstances, it is a medical decision not to attempt CPR, and patients cannot insist on treatment that is clinically inappropriate. However, it should be discussed with the patient and their relatives or carers and the reasons for the decision explained.

4 b) Successful CPR is likely to result in a length and quality of life not in the best interests of the patient
State the reasons why CPR is not felt to be appropriate. Where there is only a small chance of success and the burdens of attempting CPR may outweigh the benefits, the involvement of the patient is crucial. When the patient has capacity their own views should be the primary guide in decision-making. If the patient lacks capacity, their relatives, carers, Power of Attorney or others should be involved to explore the patient's wishes, beliefs and values to help make a "best-interests" decision. It is important they understand they are not being asked to be the final decision-makers. In cases of doubt or disagreement a second opinion should be sought.

4 c) Patient does not want to be resuscitated
State the evidence for coming to this conclusion. If a patient with capacity refuses CPR, or a patient without capacity has a valid and applicable advance decision to refuse treatment (ADRT) specifically refusing CPR, this must be respected.

Box 5 - Record of discussion
Tick the appropriate boxes and provide further information to identify the discussions that have taken place regarding this decision, and who else the information has been shared with. Discussions should be documented in more detail than this form will allow, so ensure all decisions and discussions have been fully documented in the patient's clinical notes.

5 a) Has the decision been discussed with the patient?
There should clear, accurate and honest communication with the patient, providing information about the decision and checking their understanding of what has been explained. It would not be appropriate to decide to avoid a discussion with the patient on the basis that it might cause them distress, although a patient can decline to be involved in discussions they do not wish to take part in. However, it may be deemed inappropriate to involve a patient in a discussion around CPR if

the clinician considers that to do so would be likely to cause the patient to suffer physical or psychological harm.

5 b) Has the decision been discussed with the relatives / carers / power of attorney or others?
There should also be clear, accurate and honest communication with those close to the patient (unless the patient has requested confidentiality). Where the patient lacks capacity, discussion with those close to them should be used to help guide a best-interests decision. If the patient has an attorney or court-appointed deputy, they should be consulted.

5 c) Who else has this decision been shared with?
Any decision about CPR should be communicated clearly to all those involved in the patient's care, particularly on transfer to a different healthcare setting.

In order to facilitate these, the patient and where appropriate their carer should be advised by the person completing the form, that the form can be honoured outside of the care environment where it has been completed, but they must inform others that the order exists and ensuring it is available for review in an urgent/emergency situation. A copy of the form can be forwarded to relevant healthcare professionals, **but the original must remain with the patient.**

5 d) Has a patient information leaflet been offered to the patient or family?
Organisations should ensure a relevant patient information leaflet is available for patients and those close to them. This leaflet should be offered as part of the discussion around the DNACPR decision, but should not be used as a substitute for a full verbal discussion.

Box 6 - Healthcare professional completing this DNACPR

The healthcare professional completing the form should fill in their details and sign the form. The decision must be discussed and agreed with the senior clinician responsible for the patient's care. This might be their GP, hospital consultant or out of hours practitioner depending on the setting.

The name of the responsible senior clinician the DNACPR was discussed with should be clearly documented and their agreement confirmed.

7. Situations Where There is a Lack of Agreement

7.1 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.

7.2 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.

7.3 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 clearly in the patients notes.

7.4 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.

7.5 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 from the organisations legal representatives.

8. Cancellation of DNACPR Decision

8.1 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 must be crossed through with two diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional, who will print their name and professional registration number clearly underneath their signature for purposes of validation. Without this validation the order will not be considered revoked.

8.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all relevant parties involved in the care of the patient.

9. Temporary Suspension of DNACPR Decisions

9.1 In some circumstances there are reversible causes of a cardiorespiratory arrest. These are either pre-planned or acute and it may be appropriate for the DNACPR decision to be temporarily suspended under these circumstances.

9.2 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 patient and/or carer, if appropriate, will need to take place.

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

9.4 After the event, the DNACPR decision should be reviewed and discussed with the patient and reinstated where appropriate.

10. Patients with an Implantable Cardioverter Defibrillator (ICD)

10.1 It is the responsibility of the Clinician in charge of the patients' care to address the potential need to deactivate the ***defibrillator*** function of an ICD.

10.2 The ***pacemaker*** function should remain active, even in terminally ill patients, as deactivation may potentially accelerate the dying process.

10.3 Patients deemed to be approaching end stage heart failure, or other illness, are at risk of developing complex arrhythmias which may trigger the firing of the ICD. In these circumstances, it would be inappropriate to maintain the ICD in active mode, resulting in patient distress.

10.4 In accordance with good practice, the Responsible Medical Officer/Senior Clinicians should consult with patients and their carers where appropriate, to incorporate the ICD deactivation decision process in the patients' plan of care. This should be done prior to the very end stage of life to avoid unnecessary patient mental and physical distress.

10.5 For those patients who lack capacity, Clinicians must adhere to the guidelines outlined in the 2005 Mental Capacity Act during the decision making process.

10.6 The British Heart Foundation discussion document for Health Professionals entitled; "Implantable Cardioverter Defibrillators in Patients that are reaching the end stage of life" can be accessed via the following hyperlink: http://www.bsh.org.uk/portals/2/icd%20leaflet.pdf

11. Cultural/Religious Considerations

11.1 The cultural and religious wishes of patients must be respected during the whole process.

11.2 Further information regarding this subject is available at: www.endoflifecare.nhs.uk

12. Monitoring Compliance

12.1 DNACPR forms should be collated by each clinical area and a copy of each form completed forwarded to the Trust Resuscitation Lead as soon as possible following completion.

12.2 Yearly audit should be undertaken to demonstrate compliance with the unified principles of DNACPR. This will be reported through the Trust governance structure.

13. Training Requirements

13.1 The policy and associated documents will be included in the programme as part of the Basic Life Support training sessions provided at staff induction and annual mandatory training events.

13.2 Further training requirements should be identified with managers through the appraisal process and in conjunction with the training needs analysis.

13.3 Informal arrangement exists for staff involved in the decision making process to access support and guidance from the following sources:

Policy Authors
Resuscitation Committee
Hospital Chaplaincy
Senior Management Team

14. Distribution

14.1 The policy will be available to all Trust staff via email/Trust website

14.2 A copy of the policy will be sent electronically to all Heads of Clinical Services for distribution.

14.3 Ward Managers/Clinical Leads will be responsible for ensuring relevant policy information is cascaded to all clinical staff within their area.

15. Communication

15.1 Announcement of the policy will be by circulation and it will be added to the Policies & Guidelines section of the Trust website.

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15.2 Heads of Clinical Services will be responsible for ensuring all clinical staff within their department are made aware of the policy.

15.3 References to the policy will be amended in all associated policies as appropriate.

16. References

- Advance Decision to Refuse Treatment, a guide for health and social care professionals. London: Department of Health (Accessed 18.01.16). http://www.ncpc.org.uk/sites/default/files/ADRT%20books.pdf

- British Medical Association, (2000). The impact of the Human Rights Act 1998 on medical decision-making. London, BMA Books.

- British Medical Association, (2001). Withholding or withdrawing life- prolonging medical treatment. 2nd ed. London, BMA Books.

- Coroners and Justice Act 2009 London: Crown Copyright. http://www.legislation.gov.uk/ukpga/2009/25/contents (accessed 18.01.2016)

- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland 2010 http://www.gov.scot/Resource/Doc/312784/0098903.pdf (accessed 18.01.16)

- GMC Treatment and Care Towards the end of life: good practice in decision making 2010 http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp (accessed 18.01.16)

- Human Rights Act. (1998) London: Crown Copyright. www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1 (accessed 18.01.16).

- Mental Capacity Act. (2005) London: Crown Copyright. www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1 (accessed 18.01.16).

- Resuscitation Council UK (2014) Decisions relating to cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. RC (UK) www.resus.org.uk/pages/decisionsrelatingtoCPR.pdf (accessed 18.01.16).

- Royal College of Physicians (2009) Advance Care Planning. London: Royal College of Physicians. https://www.rcplondon.ac.uk/guidelines-policy/advance-care-planning (accessed 18.01.16).

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

Appendix 1

Definitions

Staff:
All employees of LCHS including those managed by a third party organisation on behalf of LCHS.

Senior Clinician:
Is used throughout the policy to reflect the diversity of primary health care environments, the roles and responsibilities of practitioners working within those areas, for example nurse led community hospitals, community nursing, palliative care, out of hours (this list is not exclusive). This term in the context of decision making refers to the senior clinical practitioner available on duty, responsible for patient care.

Cardiopulmonary 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.

ADRT:
Advance Decision to Refuse Treatment, as defined in the Mental Capacity Act 2005. A legally binding written and witnessed document generated by the patient at a time of having mental capacity.

Do Not Attempt Cardiopulmonary 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 analgesia, fluid replacement, feeding, antibiotics and basic care.

LPA:
Lasting Power of Attorney. A legally binding document identifying the status of an individual to make decisions on behalf of the patient, regarding their medical care, inclusive of life sustaining treatments.

The 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.

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 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

Appendix 2

NHS Lincolnshire Health & Care Services, Working in Partnership

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over.

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

1. Patient Details (or affix addressograph label)

Surname .....

First Name(s) .....

Date of Birth .....

NHS Number .....

2. Date of DNACPR decision: .....

Is a review date appropriate? Yes ☐ No ☐

If Yes state planned review date:

Review Date ..... Name ..... Signature .....

3. Patients preferred place of care:

4. Reason for DNACPR decision (tick one or more boxes and provide further information below)

☐ a) CPR is unlikely to be successful because:

.....

☐ b) Successful CPR is likely to result in a length and quality of life not in the best interest of the patient because:

.....

☐ c) Patient does not want to be resuscitated as evidenced by: (e.g. documented discussion or valid ADRT)

.....

5. Record of discussion (tick one or more boxes and provide further information below)

a) Has the decision been discussed with the patient? Yes ☐ No ☐

If 'yes', record content of discussion. If 'no', state why not discussed.

Note: it would not be appropriate to avoid a discussion with the patient on the basis that it might cause them distress.

.....

.....

b) Has the decision been discussed with the relatives / carers / Power of attorney or others? Yes ☐ No ☐

If 'yes', record name, relationship and content of discussion. If 'no', state why not discussed.

.....

.....

c) Have you discussed the safekeeping of this form with the patient/carer? Yes ☐ No ☐ Details:

.....

d) Has a patient information leaflet been offered to the patient or family? Yes ☐ No ☐

If "No", state the reason .....

Ensure decisions and discussions have been documented in the patient's clinical notes.

6. Healthcare professional completing this DNACPR

(The decision for the DNACPR must be discussed with the responsible senior clinician, e.g Hospital Consultant, GP, Out of Hours Practitioner)

Name ..... Signature .....

Position ..... GMC /NMC No. .....

Date ..... Time ..... Bleep/Contact No. .....

Name of responsible senior clinician the DNACPR was discussed with: .....

Signature of Consultant discussed with (ULHT only): Date: GMC No:

This original form remains the property of the patient. If they transfer to a different healthcare setting, the original MUST go with the patient. A black & white photocopy can be made to be retained in the medical records. If the DNACPR 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, with their name and GMC/NMC number clearly identifiable.

NHS Lincolnshire Health & Care Services, Working in Partnership

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over.

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

Guidance Notes

- This DNACPR form is intended to be used countywide across Lincolnshire by all Healthcare Providers.
- This form should be completed legibly in black ball-point ink, and used in accordance with the local resuscitation policy.
- A DNACPR decision only relates to cardiopulmonary resuscitation where the patient is in cardiopulmonary arrest, not to any other form of care or treatment. All discussions relating to this decision must be documented in the patient's clinical notes.
- This form remains the property of the patient, and it is transferrable to other healthcare settings. If the patient moves to a different location, the original copy of this form MUST go with the patient, but a black and white photocopy can be retained in the medical records. The clinical team responsible for the patient must ensure their professional colleagues receiving the patient are aware of the decision.

Box	Issue	Guidance
1	Patient details	Full name, Date of Birth and NHS Number will all be entered. An addressograph label may be used providing it contains all 3 identifiers.
2	Review date	A fixed review date is not normally recommended. The decision should be regarded as indefinite unless: • A definite review date is specified. If a date is specified the form should be regarded as invalid after that date unless it has been reviewed. • There are significant changes in the patient's condition. This should prompt a review of the decision with the patient. • The patient's wishes change. This should also prompt a review of the decision with the patient.
3	Patients preferred place of care	Please enter the patients preferred place of care and update it if this changes. Establishing this forms an important part of advance care planning.
4 a)	CPR is unlikely to be successful	State the underlying condition and reasons why CPR would be unlikely to succeed. Where a patient is likely to die naturally because of an irreversible condition, not to attempt CPR is a medical decision. Patients cannot insist on treatment that is clinically inappropriate. However, it should be discussed with the patient and their relatives or carers and the reasons for the decision explained.
4 b)	Successful CPR is likely to result in a length and quality of life not in the best interest of the patient	State the reasons why CPR is not felt to be appropriate. Where there is only a small chance of success and the burdens of attempting CPR may outweigh the benefits, the involvement of the patient is crucial. When the patient has capacity their own views should be the primary guide in decision-making. If the patient lacks capacity, their relatives, carers, Power of Attorney or others should be involved to explore the patient's wishes, beliefs and values to help make a "best-interests" decision. It is important they understand they are not being asked to be the final decision-makers. In cases of doubt or disagreement a second opinion will be sought.
4 c)	Patient does not want to be resuscitated	If a patient with capacity refuses CPR, or a patient without capacity has a valid and applicable advance decision to refuse treatment (ADRT) specifically refusing CPR, this must be respected.
5	Record of discussion	There should be clear, accurate and honest communication with the patient, and with those close to them (unless the patient has requested confidentiality). It would not be appropriate to decide to avoid a discussion with the patient on the basis that it might cause them distress, although a patient can decline to be involved in discussions they do not wish to take part in. Any decision about CPR should be communicated clearly to all those involved in the patient's care, particularly on transfer to a different healthcare setting, the conversation with the patient must include how they can ensure that this decision is communicated with carers and care professionals .
6	Healthcare professional completing this DNACPR	The healthcare professional completing this form must ensure they have discussed the decision with the responsible senior clinician, and documented that they are in agreement with it. At ULHT a consultant must sign the document within 24 hours of initiation, in line with the policy.

Appendix 3

Children & Young People Below 16 Years of Age.

Introduction

It is recognised that the topic of DNACPR for anyone below 16 years of age is emotive and difficult for professionals as well as patients.

The laws and legal precedents relating to children and mental capacity together with involvement in treatment and decision principles make this an area of particular difficulty.
As such DNACPR has to be seen within the remit of an integrated care pathway that seeks to provide support to child and family following a unique care journey.

General Principles

All members of the health team, in partnership with parents, have a duty to act in the best interests of the child. This includes sustaining life, and restoring health to an acceptable standard. However there are circumstances in which treatments that merely sustain 'life' neither restore health nor confer benefit and hence are no longer in the child's' best interests.

Clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and the healthcare team.

Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. There are five situations where it may be ethical and legal to consider withholding or withdrawal of life sustaining medical treatment:

1. **The "Brain Dead" Child**. In the older child where criteria of brain stem death are agreed by two practitioners in the usual way, it may still be technically feasible to provide basal cardio-respiratory support by means of ventilation and intensive care. It is agreed within the medical profession that treatment in such circumstances is futile and the withdrawal of current medical treatment is appropriate.

2. **The "permanent Vegetative State"** The child who develops a permanent vegetative state following insults, such as trauma or hypoxia, is reliant on others for all care and does not react or relate with the outside world. It may be appropriate to withdraw or withhold life-sustaining treatment.

3. **The "No chance" Situation.** The child has such severe disease that life-sustaining treatment simply delays death without significant alleviation of suffering. Treatment to sustain life is inappropriate.

4. **The "No purpose" Situation.** Although the patient may be able to survive with treatment, the degree of physical or mental impairment will be so great that it is unreasonable to expect them to bear it.

5. **The "Unbearable" Situation.** The child and/or family feel that in the face of progressive and irreversible illness further treatment is more than can be borne. They wish to have a particular treatment withdrawn or to refuse further treatment irrespective of the medical opinion that it may be of some benefit.

"In situations that do not fit these five categories or where there is uncertainty about the degree of future impairment or disagreement, the child's life should always be safeguarded in the best way possible by all the Health Care Team until these issues are resolved. Decisions must never be rushed and must always be made by the team with all evidence available." (*Royal College of Paediatrics and Child Health, 2004: Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice*).

Procedure

Within LCHS the process of generation of DNACPR status for a child or young person will only follow the involvement of the multi-disciplinary team in production of a care plan and pathway of care except in exceptional emergency situations.

The Together For Shorter Lives Charity has produced a guidance document that explains the process of pathway generation and standards that should be reached.
http://www.togetherforshortlives.org.uk/assets/0000/4121/TfSL_A_Core_Care_Pathway__ONLINE_.pdf

Should a child present to LCHS services with an advanced care plan in place it is important staff contact those directly involved with the child's care so as to appreciate what may be required. The child may have a 'single point of contact' in place or be subject to a keyworker process and communication with the family is imperative to ensure elements of the agreed plan can be actioned as envisaged. The senior treating clinician, generally named in the care plan, remains the primary reference point regarding the nature of advanced care plans for children and young people.

At present no national or locally recognised DNACPR Form exists for children, however a model was created by the Resuscitation Council (UK).
https://www.resus.org.uk/EasySiteWeb/GatewayLink.aspx?alId=3868

Should a child present to LCHS services with a not immediately recognisable DNACPR form, such as from another area, unless there is a good reason to believe the DNACPR decision is not genuine or applicable, it should be accepted as valid until the decision is reviewed by the patient's responsible senior clinician. Similarly, a photocopy of a DNACPR form should be accepted unless there is evidence it should not be considered valid.

In emergency situations full information may not be available, it is therefore impractical to suggest that informed decisions based on consultation will be possible. "In acute situations it is always necessary to give life-sustaining treatment first and to review this when enough information is available, from more experienced opinion or following the evolution of the clinical state or in the light of investigations." (*Royal College of Paediatrics and Child Health, 2004: Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice*).

Appendix 4

Patient Leaflets

1.Your guide to Decisions about Cardiopulmonary Resuscitation

DNACPR Patient leaflet_A4[1].pdf

http://www.adrt.nhs.uk/pdf/DNACPR-Patient-leaflet-A4.pdf

2.Planning for your future care.

Planning for your future care updated !

http://www.nhs.uk/livewell/endoflifecare/documents/planning_your_future_care%5B1%5D.pdf

Equality Analysis

Name of Policy/Procedure/Function* Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
(incorporating Lincolnshire Unified Principles for Adult Do Not Attempt Cardiopulmonary Resuscitation)

Equality Analysis Carried out by: Tim Balderstone
Date: 14 April 2016

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	This policy aims to ensure that all healthcare professionals working within Lincolnshire Community Health Services NHS Trust are aware of the legal and ethical issues regarding cardiopulmonary resuscitation and Do Not Attempt Resuscitation and are enabled to adopt practices which aim to ensure the understanding and support of the patient and thus minimise the risk of legal challenge. The policy provides supportive information and tools to support decision making.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	Impacts on patients and staff		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?			
		Yes	No	
	Disability		x	
	Sexual Orientation		x	
	Sex		x	
	Gender Reassignment		x	
	Race		x	
	Marriage/Civil Partnership		x	
	Maternity/Pregnancy		x	
	Age		x	
	Religion or Belief		x	
	Carers		x	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
	Equality Analysis Carried out by:	Tim Balderstone		
	Date:	12/4/16		

Appendix 6

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/ audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Number of DNACPR Decisions	DNACPR Form audit	Patient Safety Collaborative	Quarterly	Patient Safety Collaborative	Patient Safety Collaborative	Patient Safety Collaborative
Compliance with the Unified Principles	DNACPR Form audit	Patient Safety Collaborative	Yearly	Patient Safety Collaborative	Patient Safety Collaborative	Patient Safety Collaborative