

(DNAR) Do Not Attempt Cardio Pulmonary Resuscitation In Adults and Children Policy 2.0			
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Originating service:	Resuscitation Committee		
Purpose of document:	This document will make clear to staff the procedures that should be followed when a patient is identified as benefiting from a Do Not Attempt Cardio-Pulmonary Resuscitation Order (DNACPR). It will also cover admission and discharges of patients with existing DNACPR orders at home or from other institutions e.g. nursing homes and hospices).		
Scope:	Trust wide		
Standards & legislation:	This document supports Care Quality Commission Fundamentals of Care standards. Decisions relating to cardiopulmonary resuscitation		
Approved by:	Quality and Professional Practice Team		
Date approved:	March 2017	Review date:	March 2020
Key related documents:	<ul style="list-style-type: none"> <li>Deteriorating Patient Policy</li> <li>NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy for Adults (2011)</li> <li>Adult Basic Life Support Procedure</li> <li>Clinical Handover of Care &amp; Discharge Policy</li> <li>Medical Devices Management Policy and Procedure</li> <li>Records Management Policy</li> <li>Mental Capacity and deprivation of Liberty Safeguards Policy</li> <li>Clinical Protocol for Assessing Mental Capacity and Best Interests</li> <li>Incident Reporting Policy</li> </ul>		
Equality & Diversity Impact:	The document owner has carried out an EDIA on this document and there are no negative impacts.		
Financial implications:	Where a document has any financial implications on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document in regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place. LCFS contact details are available on the Trust's Intranet.		
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# **VERSION CONTROL SUMMARY**

Version	Page No.	Description of change	Date approved
1	N/A	First issue	May 2014
1.1	All	Document Control Template updated to include:- NHS Litigation Authority Standards removed CQC Fundamentals of Care updated EDIA Tool added or updated Job titles, roles and committee structures updated	May 2016
2	All	Reviewed & updated	March 2017

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## **1.0 Introduction**

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 (a) 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. (b)

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 cardiorespiratory arrest and who competently refuse this treatment option.

## **2.0 Policy Statement**

- 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 Trust. It does not refer to other aspects of care, for example, analgesia, antibiotics, suction, and 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 Trust’s 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.

### **3.0 Purpose**

- 3.1 This policy will provide a framework to ensure that DNACPR decisions:
  - Respect the wishes of the individual, where possible.
  - Reflect the best interests of the individual.
  - 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.

### **4.0 Scope**

- 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 Trust's services.
- 4.2 This policy can be applied to all individuals over the age of 16 years.

### **5.0 Legislation**

- 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 Respect for privacy and family life (article 8).

In considering decisions about treatment in relation to the Act, the courts have indicated that the degree of patient involvement required by Article 8 depends on the particular circumstances of the case, and notably the nature of the decisions to be taken. An individual has to be involved in the decision-making process, seen as a whole, to a degree sufficient to provide her or him with the requisite protection of their interests.(2)

In 2014 the Court of Appeal concluded that when a decision about CPR is being considered “there should be a presumption in favour of patient involvement and that there need to be convincing reasons not to involve the patient”(3) and went on to say “However, it is inappropriate (and therefore not a requirement of article 8) to involve the patient in the process if the clinician considers that to do so is likely to cause the person to suffer physical or psychological harm”.(4) A subsequent High Court ruling in 2015 noted (also in relation to article 8 of the Act) a presumption in favour of involving those close to an adult who lacks capacity, whenever practicable and appropriate.(5)

#### 5.1.4 An Equality Impact Assessment (EIA) has been carried out for this document.

### 6.0 Roles and Responsibilities

- 6.1 This policy and its forms / appendices are relevant to all clinical staff across all sectors and settings of. It applies to all designations and roles. It applies to all people employed in a caring capacity.
- 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, Senior Nurse, 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 Chief Executives of provider organisations are responsible for:
  - Governance compliance for the policy and procedure.
  - Procuring and / or providing legal support.
- 6.5 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 understands 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.

- 6.6 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.
- 6.7 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.

## **7.0 Procedure**

- 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.
- 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.
- 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 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.

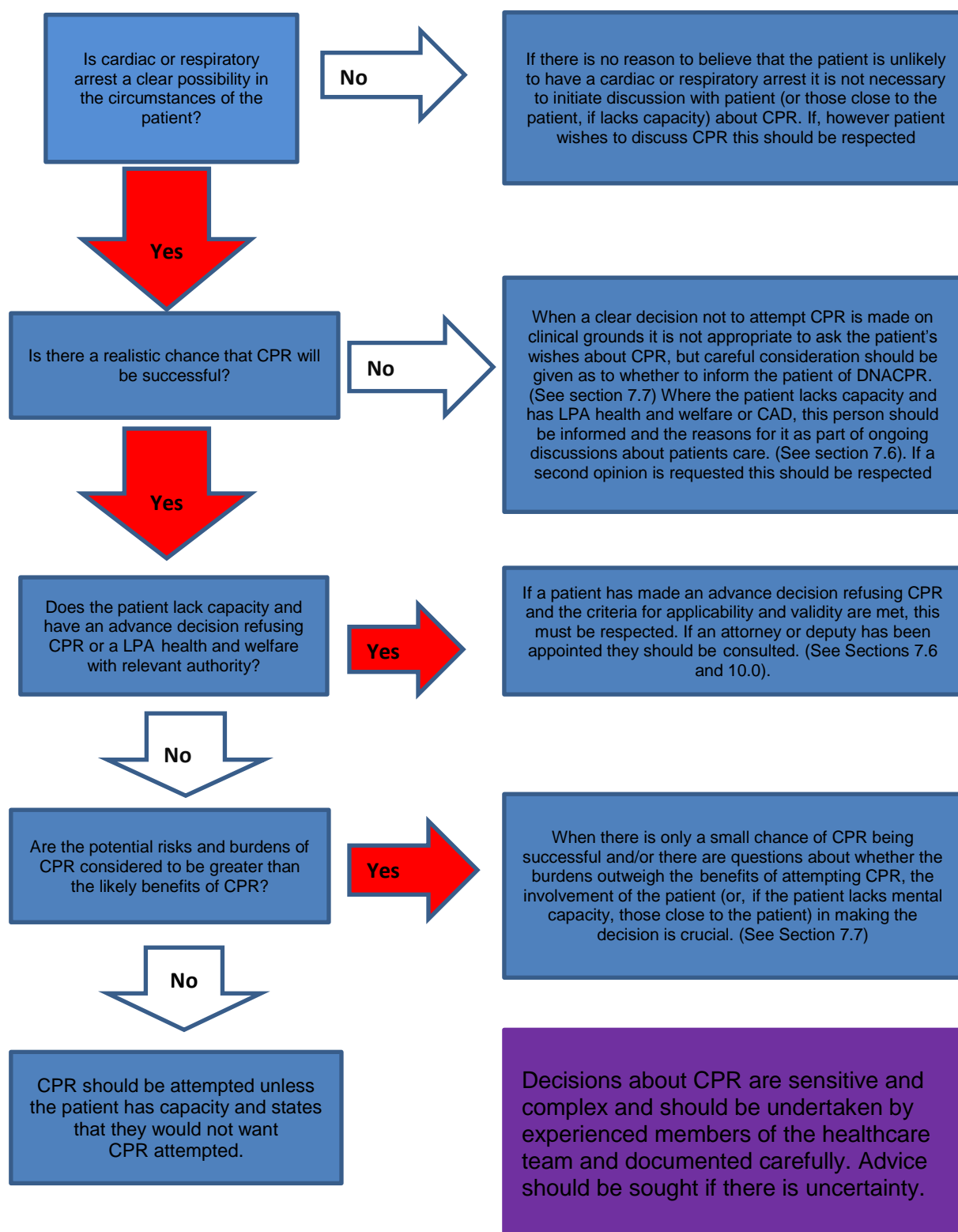
- 7.7 If a DNACPR discussion and decision is deemed appropriate the following need to be considered:
- It is rarely appropriate to discuss DNACPR decisions in isolation from other aspects of end of life care. DNACPR is only one small aspect of advance care planning which can help patients achieve their 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) should be made available, 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, opportunities to sensitively inform patients and relevant others should be sought unless it is judged that the burden of such a discussion would outweigh the possible benefit for the individual patient.
- 7.8 Documenting and communicating the decision
- Once the decision has been made it must be recorded on the NHS East of England 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.

## **8.0 Summary Decision Making Framework**

See next page.

### Summary Decision Making Framework



## **9.0 Review**

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.

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

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. On-going patient education, a period of time for reflection and opportunities for discussion will often result in agreement.

10.2.1 In a judgment in the Court of Appeal the Master of the Rolls stated:

*"In my view, doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardio-respiratory arrest. If however the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her. I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find that such decisions, if conscientiously taken, violate*

*a patient's rights under article 8 of the Convention." (1)*

10.2.2 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.

10.2.3 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.

## **11.0 Cancellation of a DNACPR Decision**

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.

## **12.0 Suspension of DNACPR Decision**

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.

## **13.0 Clinical Governance**

13.1 The Trust 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.

## **14.0 Definitions**

- 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 the 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.

## 15.0 Audit and Monitoring

Measurable document objectives i.e what will be monitored	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to group/ committee
The process for The effectiveness of the policy (DNAR) Do Not Attempt Cardio Pulmonary Resuscitation In Adults and Children for Cambridgeshire Community Service	Review of The processes in place to ensure the patient receives the correct processes during this activity	annually	The DNACPR and EoL Group	Clinical Scrutiny committee

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Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Council, the Resuscitation Council (UK) and The Royal College of Nursing (previously known as the joint statement) 3<sup>rd</sup> Edition (1<sup>st</sup> Revision) 2016 accessed 06/07/2016 (a,b)

(1) R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:54.


(2) Tysiac v Poland [2007] 45 EHRR 42.

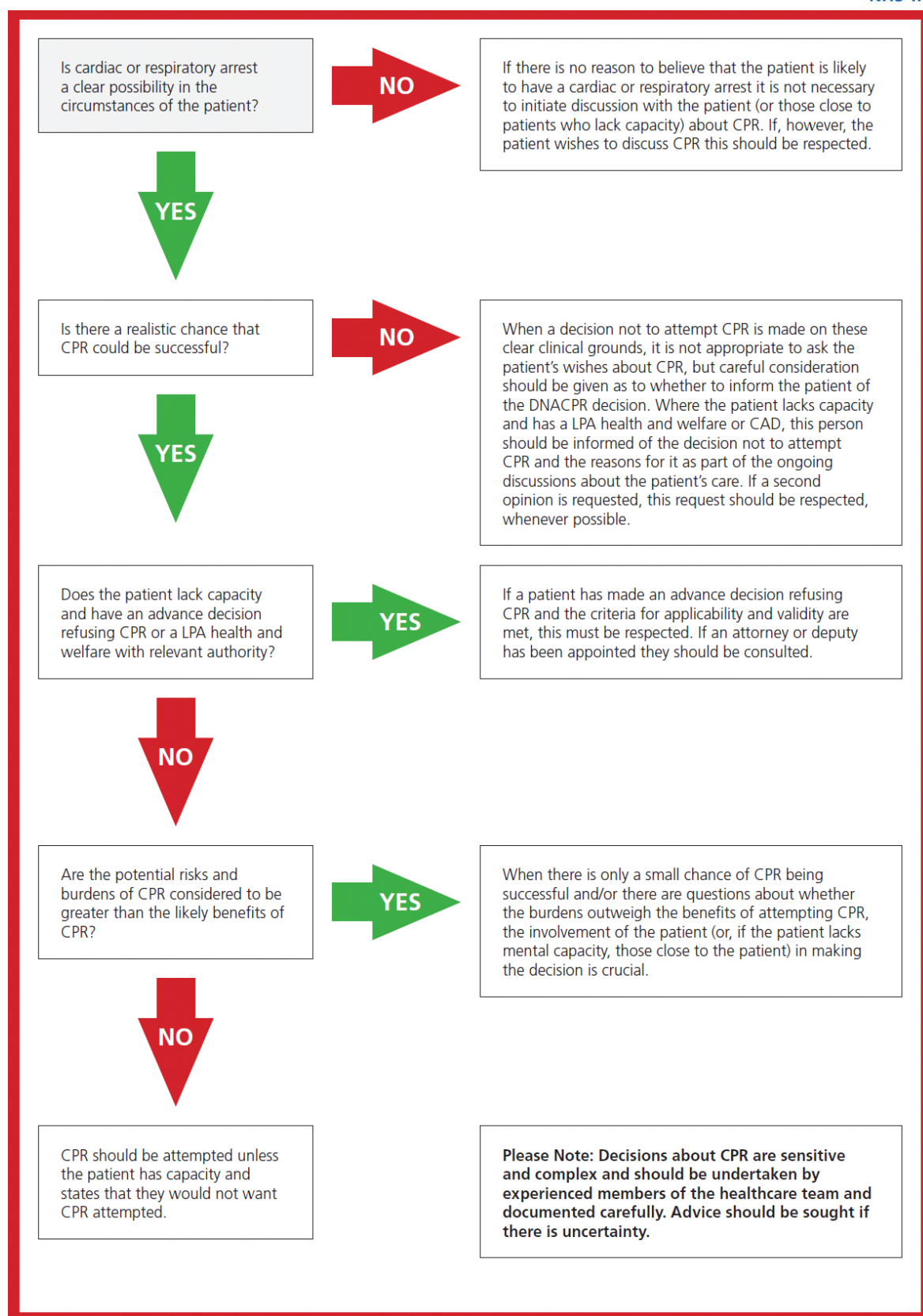
(3) R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:53.

(4) R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:54.

(5) Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB).

Appendix 1 – double click on form to open document

<p><b>DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION</b>  <b>Adults aged 16 years and over</b>  <b>In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR)</b>  <b>All other appropriate treatment and care will be provided</b></p>							
<p><b>Name:</b> _____</p> <p><b>Address:</b> _____</p> <p>_____</p> <p><b>Date of birth:</b>     /     /</p> <p><b>NHS or hospital number:</b> _____</p>	<div style="text-align: right;">  </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Date of DNACPR order:</b></p> <p>_____ / _____ / _____</p> </div>						
<p><b>Reason for DNACPR decision (tick one or more boxes and provide further information)</b></p> <p><input type="checkbox"/> CPR is unlikely to be successful [i.e. medically futile] because:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Patient does not want to be resuscitated as evidenced by:</p> <p>_____</p> <p>_____</p>							
<p><b>Record of discussion of decision (tick one or more boxes and provide further information)</b></p> <p>Discussed with the patient / Lasting Power of Attorney [welfare]? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>          If 'yes' record content of discussion. If 'no' say why not discussed.</p> <p>_____</p> <p>_____</p> <p>Discussed with relatives/carers/others? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>          If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.</p> <p>_____</p> <p>_____</p> <p>Discussed with other members of the health care team? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>          If 'yes' record name, role and content of discussion. If 'no' say why not discussed.</p> <p>_____</p> <p>_____</p>							
<p><b>Healthcare professional completing this DNACPR order</b></p> <table style="width: 100%;"> <tr> <td style="width: 50%;">Name: _____</td> <td style="width: 50%;">Signature: _____</td> </tr> <tr> <td>Position: _____</td> <td>Date:     /     /     Time: _____</td> </tr> </table>		Name: _____	Signature: _____	Position: _____	Date:     /     /     Time: _____		
Name: _____	Signature: _____						
Position: _____	Date:     /     /     Time: _____						
<p><b>Review and endorsement by responsible senior clinician</b></p> <table style="width: 100%;"> <tr> <td style="width: 50%;">Name: _____</td> <td style="width: 50%;">Signature: _____</td> </tr> <tr> <td>Position: _____</td> <td>Date:     /     /     Time: _____</td> </tr> <tr> <td>Is DNACPR decision indefinite? Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>If 'no' specify review date:     /     /</td> </tr> </table>		Name: _____	Signature: _____	Position: _____	Date:     /     /     Time: _____	Is DNACPR decision indefinite? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'no' specify review date:     /     /
Name: _____	Signature: _____						
Position: _____	Date:     /     /     Time: _____						
Is DNACPR decision indefinite? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'no' specify review date:     /     /						



Appendix 2 – double click on page to open document



# Cardiopulmonary Resuscitation (CPR)

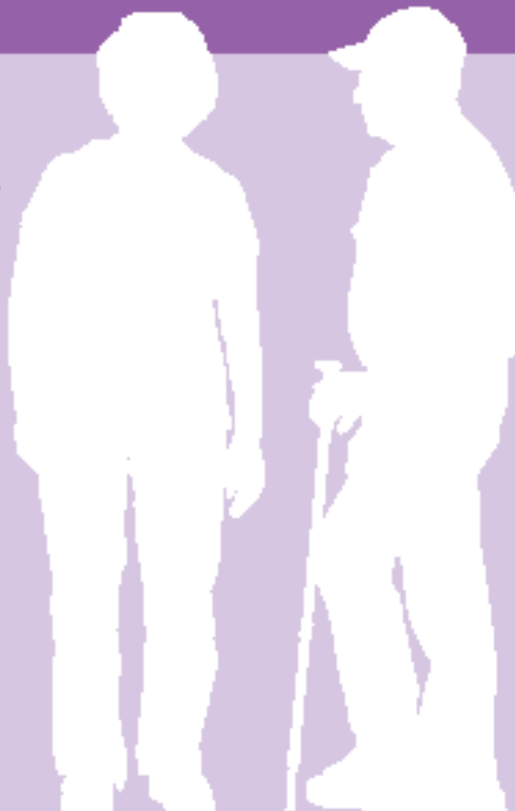
## Patient Information Leaflet

### **This leaflet explains:**

- 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.



### Rapid Equality and Diversity Impact Assessment Tool

The purpose of an Equality Impact Assessment is to improve the work of the Trust by ensuring that it does not discriminate and that, where possible, promotes equality. It is a way to ensure individuals and teams think carefully about the likely impact of their work on service users and take action to improve activities, where appropriate. As a public authority the Trust is required to carry out an assessment on all of its approved documents.

Name of document being assessed:	Do Not Attempt Cardio Pulmonary Resuscitation Policy
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#### State the name and job role of the reviewer:

Name:	Jennie Russell
Job Role:	Head of Professional Practice
Date:	May 2016
<b>Choose either Positive or Negative impact. POSITIVE it could benefit or would have very little or no impact. NEGATIVE, it could disadvantage. If you choose NEGATIVE you will be required to complete a FULL EQUALITY IMPACT ASSESSMENT</b>	
Minority ethnic including Gypsy/travellers, refugees and asylum seekers	Positive
Women and men	Positive
People in religious/faith groups	Positive
Disabled people	Positive
Older people	Positive
Children and young people	Positive
Lesbian, gay, bisexual and transgender people	Positive
Marriage and Civil Partnership status	Positive
Maternity status	Positive
People of low income	Positive
People with learning disabilities	Positive
People with mental health problems	Positive
Homeless people	Positive
People involved in criminal justice system	Positive
Staff	Positive
Diet and nutrition	Positive
Exercise and physical activity	Positive
Substance use: tobacco, alcohol or drugs	Positive
Risk taking behaviour	Positive
Education and learning, or skills	Positive
Social status	Positive
Employment (paid or unpaid)	Positive
Social family support	Positive
Stress	Positive
Income	Positive

Discrimination	Positive
Equality of opportunity	Positive
Relations between groups	Positive
Living conditions	Positive
Working conditions	Positive
Pollution or climate change	Positive
Accidental injuries or public safety	Positive
Transmission of infectious disease	Positive
Health care	Positive
Transport	Positive
Social services	Positive
Housing services	Positive
Education	Positive
Any other areas	Positive
Were any NEGATIVE impacts identified?	NO
<b>If YES please contact the Assistant Director of Corporate Governance who is the Equality &amp; Diversity Lead for the Trust to complete a full Equality Impact Assessment</b>	