REF: CG06

VERSION: 11.0

North Cumbria University Hospitals NHS Trust

Do Not Attempt Cardio Pulmonary Resuscitation Policy (DNACPR)

SUMMARY & AIM

This policy provides updated guidance on the provision of Do Not Attempt Cardio Pulmonary Resuscitation orders for patients within North Cumbria University Hospitals NHS Trust and includes the following:

- Requirements for audit.
- Reference to the Mental Capacity Act.

TARGET AUDIENCE:

Nurses, doctors, consultants.

TRAINING:

Staff responsible for dealing with DNACPR orders must read this policy and Decisions relating to Cardiopulmonary Resuscitation – Guidance from the BMA, RC(UK) and RCN.

Staff responsible for dealing with DNACPR orders must complete Mental Capacity Act Level 1 via Trust elearning workbook and / or complete Level 2 learning as indicated on their TNA .

EVIDENCE OF IMPLEMENTATION:

Bi-annual compliance audit of DNACPR forms presented to the Resuscitation Committee

Mental Capacity Act Mandatory Training Level 1 & 2 compliance is monitored and reviewed monthly at Workforce Committee

KEY REQUIREMENTS

1. A DNACPR decision must be appropriate to the individual circumstances of each patient.
2. In the event of no explicit advanced decision there is a presumption that health professionals will make all reasonable efforts to revive the patient in the event of a cardiac or respiratory arrest.
3. There is a legal duty to consult in cases of capacity and in the absence of capacity. If the healthcare team believe that CPR will not re-start the heart & breathing, this must be explained to the patient or relevant others for those who lack capacity.
4. If the patient or their family do not accept the decision a second opinion must be arranged.
5. Section 5.3 lists circumstances to be considered in the decision to implement a DNACPR notice.
6. A statutory test of capacity must be conducted in the event of implementation of a DNACPR notice.
7. When a patient is deemed not to have capacity, the clinical team implementing a DNACPR notice must use the Best Interest Checklist
9. Full details must be documented in the patient's medical records following completion of the Trust DNACPR form.

DOCUMENT CONTROL

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Please note that the Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.	

History of previous published versions of this document:

Date Approved by Sub Committee	Date Ratified by TPG	Version	Issue Date	Review Date	Policy Author Details
15/02/2016	03/05/2016	10.0	03/05/2016	31/05/2017	Charlotte McNally / Resuscitation Officer
15/02/2016	03/05/2016	9.0	03/05/2016	31/05/2017	Charlotte McNally / Resuscitation Officer
20/05/2015	15/10/2015	8.0	20/10/2015	31/05/2017	Charlotte McNally / Resuscitation Officer
20/05/2015	23/07/2015	7.0	04/09/2015	31/05/2017	Charlotte McNally / Resuscitation Officer
20/05/2015	23/07/2015	6.0	03/09/2015	31/05/2017	Charlotte McNally / Resuscitation Officer
19/03/2013	16/04/2013	5.0	11/03/2015	30/04/2015	Dave Miller / Bob Crabb Resuscitation Officers
19/03/2013	16/04/2013	4.0	18/04/2013	30/04/2015	Dave Miller / Bob Crabb Resuscitation Officers
12/05/2010	02/12/2010	3.0	14/02/2010	31/12/2012	Dave Miller / Bob Crabb Resuscitation Officers
19/09/2007	30/11/2007	2.0	22/01/2008	22/01/2010	Bob Crabb Resuscitation Officer
-	-	1.0	-	-	-

Statement of changes made from version 10.0

Version	Date	Section & Description
10.1	08/02/2017	• Change of Medical Director. • Section 2 – Removal of In Hospital survival figures. • Section 4.3 – Addition of Resuscitation Committee responsibilities. • Section 4.4 – Addition of Trust Resuscitation Officers Responsibilities. • Section 6.10 – Ensure patient I.D stickers on both copies of DNACPR form. • Section 7 – Addition to Training & Support. • Addition Appendix 3 – Guidance notes. • Section 6.1 & 6.4 – Word change from 'competently' to 'capacitous', guidance from Adult Safeguarding Lead. • Section 6.7 – Distinction between competency and capacity in children, guidance from Adult Safeguarding Lead. • Section 6.9 – Addition, Capacity decision.
10.2	05/052017	• Section 6.4, Children – section updated to clearly define what is documented; • Section 7, Training and Support – statement relating to 'reading of the policy document and the joint statement from the BMA' removed; • Section 8, Monitoring compliance, row 2 – changed 'committee' to 'group'; • Section 8, Monitoring compliance 'Grand Medical Rounds' replaced with 'Trust Clinical Teaching Sessions'; • Section 9, References – added 'Mental Capacity Act';
10.3	08/05/2017	• Appendix 2 updated • Section 6.8 amended to include DNACPR form (Acute or Community)

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Rod Harpin	Medical Director	08/02/17
Kathy Barnes	Head of Clinical Standards	08/02/17
Simon Jones	Resuscitation Committee Chair	08/02/17
Carrie Dees	Litigation Manager	08/02/17
Emma Kirkman	Bereavement Specialist Nurse	08/02/17
Susan Harkness	Critical Care Outreach Nurse	08/02/17
James Shawcross	Consultant Physician/clinical lead Med	08/02/17
Olu Orugun	Associate Medical Director	08/02/17
Denis Burke	Associate Medical Director	08/02/17
Tony Walker	Adult Safeguarding Lead	03/03/17
Trust Resuscitation Committee		28/02/17
End of Life Group		02/03/17
NM & AHP Group		20/03/17

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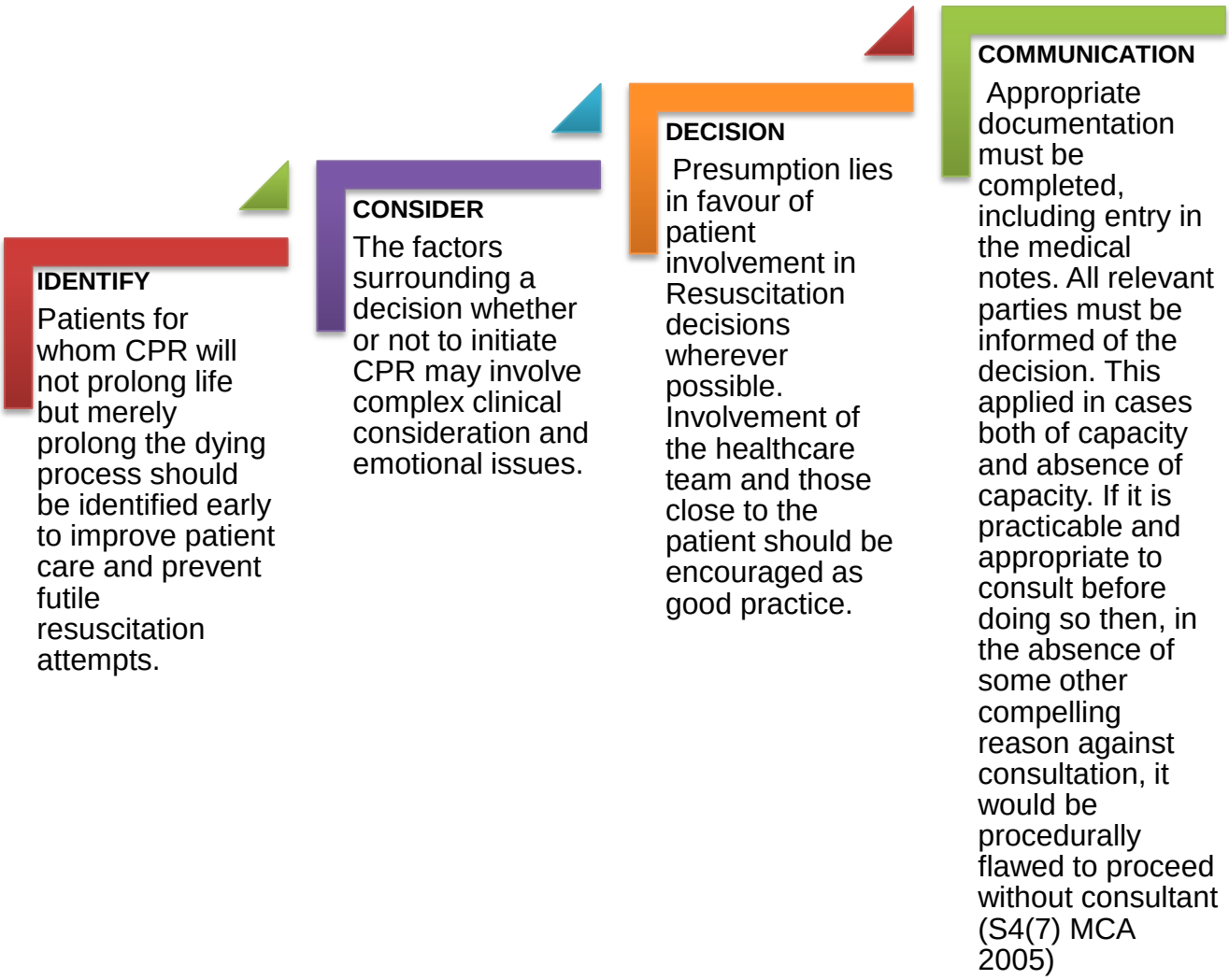
1. SUMMARY FLOW CHART

Do not attempt cardio pulmonary resuscitation policy DNACPR



2. INTRODUCTION

Cardiopulmonary Resuscitation (CPR) is undertaken in an attempt to restore breathing (sometimes with support) and spontaneous circulation in a patient in cardiac and/or respiratory arrest.
CPR is a relatively invasive medical therapy and usually includes chest compressions, attempted defibrillation with electric shocks, injection of drugs and ventilation of the lungs. In some cases spontaneous cardiac function may be restored with prompt use of an electric shock alone.

In – hospital resuscitation now often involves attempted CPR, even when the underlying condition and general health of the patient makes success unlikely.
Patients for whom CPR will not prolong life, but merely prolong the dying process should be identified early.

Improved knowledge, training and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision making should improve patient care and prevent futile resuscitation attempts.

Presumption lies in favour of patient involvement in such decisions, involvement of the healthcare team and people close to the patient should be encouraged as good practice.

The factors surrounding a decision whether or not to initiate CPR involve complex clinical considerations and emotional issues.

A decision by clinical staff not to resuscitate a patient should not be based on age, gender, mental capacity or any other discriminatory factor. The decision not to resuscitate a patient who is coming to the end of their life should be regarded as humane and compatible with compassionate care as a resuscitation attempt may be deemed to be undignified or intrusive.

There are two levels of application for DNACPR decisions:

1. Do NOT attempt cardiopulmonary Resuscitation (DNACPR) – when a patient is suffering from an illness from which recovery is not expected or if attempts at CPR would be regarded as futile.

   In such a case, cessation of cardiac and or respiratory function would be regarded as a terminal event. This decision is still compatible with maximum medical and nursing effort in treating the patient.

2. NOT for further active treatment – This would include withholding CPR. This is a complex clinical decision and should only be applied to a patient in the terminal phase of disease in whom the quality of life cannot be improved by further treatment and who would be for symptom control only. Doctors cannot be compelled to apply treatment that they feel is inappropriate or meddlesome.

3. PURPOSE OF THE DOCUMENT

This policy provides guidance on the provision of Do Not Attempt Resuscitation orders for patients within North Cumbria University Hospitals NHS Trust

4. DUTIES (ROLES & RESPONSIBILITIES)

4.1 CEO / Board Responsibilities

The Chief Executive and NCUH Trust Executive Board will ensure that appropriate resuscitation policies which respect patients' rights are in place, understood by all relevant staff, and accessible to those who need them, and that such policies are subject to appropriate audit and monitoring arrangements.

4.2 Director Responsibilities

The Medical Director has the executive responsibility for Do not attempt Cardio Pulmonary Resuscitation Policy (DNACPR) integration and compliance within the Trust.

4.3 Trust Resuscitation Committee Responsibilities

The Trust Resuscitation Committee will review this policy every two years or sooner if recommended guidance changes.
DNACPR continues to be a standing agenda item at the quarterly Resuscitation Committee meetings. The Committee will also review data collected from the bi – annual audit of in – patient DNACPR forms, frequency of review may be increased as required by the Trust.

4.4 Trust Resuscitation Officer Responsibilities

The Resuscitation Officers will collect and collate the Trust DNACPR audit data. Data will be reported to the Trust Resuscitation Committee and the Trust Medical Director Bi – annually, or more frequently as required.

4.5 General Manager / Clinical Director Responsibilities

General Managers and Clinical Directors will ensure that this policy is understood by relevant staff and that the policy is accessible at all times.

4.6 Line Managers Responsibilities

Line managers will ensure that this policy is understood by relevant staff and that the policy is accessible at all times.

4.7 Staff Responsibilities

Staff who would be expected to utilise this policy will receive training in its application. Staff have a responsibility to follow this policy in conjunction with the guidance document provided by the British Medical Association, Resuscitation Council and Royal College of Nursing.
/https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

5. DEFINITION OF TERMS USED

ABBREVIATION	DEFINITION
BMA	British Medical Association
CPR	Cardiopulmonary resuscitation
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
IMCA	Independent Mental Capacity Advocate
MCA	Mental Capacity Act
NCUH	North Cumbria University Hospitals
NHSLA	National Health Service Litigation Authority
RCN	Royal College of Nursing
RC (UK)	Resuscitation Council of the United Kingdom
UN	United Nations

6. POLICY

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the patient's age, disability, or on a professional's subjective view of a patient's quality of life.

When assessing whether attempting CPR may benefit the patient, decision-makers must not be unduly influenced by any of their own pre-existing (negative or positive) views about living with a particular condition or disability. The key issue to consider is not the decision-maker's view of the patient's disability or level of recovery that can reasonably be expected following CPR but an objective assessment of what is in the best interests of the patient, taking account of all relevant factors, particularly the patient's own views.

6.1 Advance Care Planning

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.

It is widely accepted that 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.

Patients admitted to NCUH with a valid and applicable DNACPR form from another organisation or care setting should be recognised and accepted by Health Care staff, until a time that the information may be transferred onto the Trust standard DNACPR form.
Any valid applicable advance directive (anticipatory refusal or living will), a patient's informed and capacitous refusal, which relates to the circumstances that have arisen, is legally binding upon doctors.

6.2 Presumption in favour of CPR when there is no DNACPR decision.

If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to attempt to revive the patient in the event of cardiac or respiratory arrest. In such emergencies there will rarely be time to make a proper assessment of the patient's condition and the likely outcome of CPR and so attempting CPR will usually be appropriate. Medical and nursing colleagues should support anyone attempting CPR in such circumstances.

There may be some situations in which CPR is commenced on this basis, but during attempted resuscitation further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR order or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.

Uncommonly, some patients for whom a DNACPR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.
In addition to readily reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiopulmonary arrest – for example, cardiac catheterisation, pacemaker insertion, or surgical operations.

General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment. Many routine interventions used during anaesthesia (for example tracheal intubation, mechanical ventilation or injection of vasoactive drugs) may be regarded as resuscitative measures. Under these circumstances, where there are often easily reversible causes of a cardiorespiratory arrest, survival rates are much higher than those following other causes of in-hospital cardiac arrest. DNACPR decisions should be reviewed in advance of the procedure. Ideally this should be discussed with the patient or their representative if they lack capacity, as part of the consent process. Some patients may wish a DNACPR decision to remain valid despite the increased risk of a cardiorespiratory arrest and the presence of potentially reversible causes; others

will request that the DNACPR decision is suspended temporarily. The time at which the DNACPR decision is reinstated should also be discussed and agreed.

If a patient wishes an advanced decision refusing CPR to remain valid during a procedure or treatment that increases the risk of or induces cardiorespiratory arrest, the patient must be made aware, where possible that this may significantly increase the risks of the procedure or treatment. If a clinician believes that the procedure or treatment would not be successful with the DNACPR order still in place, it would be reasonable not to proceed.

6.3 Requests for CPR in situations where it will not be successful

Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. If the healthcare team believes that CPR will not re-start the heart and breathing, this must be explained to the patient. These discussions informing the patient of the healthcare team's decision may be difficult and must be carried out by experienced senior clinicians.

If the patient does not accept the decision and requests a second opinion, this must be arranged whenever possible. Similarly, if those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation for its basis, a second opinion must be offered.

6.4 Consider a Do Not Attempt Resuscitation (DNACPR) decision in the following circumstances:

- Where the patient's condition indicates that effective CPR is unlikely to be successful.

- Where CPR is not in accordance with the recorded, sustained wishes of the patient who is mentally competent.

- Where CPR is not in accordance with a valid applicable advance directive (anticipatory refusal or living will). A patient's informed and capacitous refusal, which relates to the circumstances that have arisen, is legally binding upon doctors.

- Where successful CPR is likely to be followed by a length and quality of life, which would not be in the best interests of the patient to sustain.

The following principles must be taken into account when making decisions about DNACPR decisions:

1. A person must be assumed to have capacity unless it is established that they lack capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success

3. A competent adult has the right to make unwise decisions

4. Where a person over 16 lacks capacity, treatment decisions must be made on the basis of what is in that person's best interests

5. The treatment chosen should be wherever possible the treatment that interferes least with the patient's rights or freedoms

6.5 The Statutory Test of Capacity

The Mental Capacity Act sets out a two-stage test of capacity.

1) Does the individual concerned have an impairment of, disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?
2) Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make the specific decision.

   Also, capacity can fluctuate with time – an individual may lack capacity at one point in time, but may be able to make the same decision at a later point in time. Where appropriate, individuals should be allowed the time to make a decision themselves.

   In relation to point 2 above, the Mental Capacity Act says a person is unable to make a decision if they cannot:

   - Understand the information relevant to the decision
   - Retain that information
   - Use or weigh up that information as part of the process of making the decision

     If they aren't able to do any of the above three things or communicate their decision (by talking, using sign language, or through any other means), the Mental Capacity Act says they will be treated as unable to make the specific decision in question.

6.6 Best Interests Checklist

A fundamental principle of the Mental Capacity Act 2005 is that any act or decision made on behalf of a person who lacks capacity must be done or made in that person's 'best interests'. In such a situation the Consultant/ decision maker must therefore be satisfied that a decision that a patient is not for cardiopulmonary resuscitation is in the patients 'best interests. In ascertaining this, the Consultant/ decision maker must consider the 'best interest checklist' set out in the Mental Capacity Act 2005.

This checklist is as follows: -

a) Patients have a right, under article 8 of the European Convention on Human Rights, to have DNACPR decisions explained to them by care staff, and be consulted/informed about DNACPR decisions- the presumption lies in favour of patient involvement in these decisions.
Section 4(7) of the MCA 2005 imposes a legal duty on Clinicians to consult the patient (with or without capacity); the fact that patient may find the topic distressing is a not a sufficient reason on its own to warrant their exclusion. Clear and comprehensive reasons for excluding the patient from the discussions, and the decision to make a DNACPR order should be recorded.

b) The consultant/ decision maker must take into consideration all relevant factors and should identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.

c) The consultant/decision maker must attempt to find out the views of the patient, including their past and present wishes and feelings, which may have been expressed verbally in writing or through behavioural habits. Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence them in this decision should also be considered.

d) Avoid discrimination; the person making the CPR decision must not make assumptions about the patient's best interests simply on the basis of the patient's age, appearance, condition or behaviour.

e) The consultant/decision maker must consider whether the patient might regain capacity and if so whether the decision as to whether or not CPR will be appropriate in the future can wait until then.

f) The decision that a patient is not for CPR must not be motivated in way by a desire to bring about the patient's death and assumptions must not be made about the patient's quality of life; the starting point is that it will usually be in a patient's best interests for life to continue.

g) Consult others – the consultant/decision maker should consult other people for their views about the patient's best interests, to see if they have any information about the person's wishes, feelings, beliefs and values. In particular the following must where possible be consulted if this is practical and appropriate:-

- Anyone previously named by the patient as someone to be consulted in relation to CPR issues or similar issues.

- Anyone engaged in caring for the person such as other members of the care team.

- Close relatives, friends or others who take an interest in the patient's welfare.

- An Attorney (for Health & Care decisions) appointed under a Lasting Power of Attorney or Enduring Power of attorney made by the person.

- Any Deputy appointed by the Court of Protection to make decisions for the person.

- Where there is no such person to consult and the decision is not urgent it may be necessary to make a referral to the Independent Mental Capacity Advocate (IMCA) service. Where such a referral is made the IMCA's views on whether due process has been followed should be taken into consideration by the Consultant when making a CPR decision.

Please refer to the Trusts General Policy on the Mental Capacity Act 2005.
http://nww.staffweb.cumbria.nhs.uk/policies/categories/clinical-governance/mental-capacity-act-policy.pdf

A careful note must be made in the patient notes and DNACPR form as to who was consulted and what their views were, together with any reasons why a particular view was not agreed as being in the patient's best interests by the decision-maker.

The final decision is that of the Consultant /decision maker. He or she must consider all of the above in deciding whether a 'not for CPR' decision is in the patient's best interests.

6.7 Children

The UN Convention on the Rights of the Child defines a child as everyone under 18 unless, "under the law applicable to the child, majority is attained earlier". The UK has ratified this convention.

Once a child reaches the age of 16 they are presumed in law to be able to make competent decisions regarding medical care and therefore should be treated as an adult.

It is widely recognised that medical decisions relating to children and young people ideally should be taken within a supportive partnership involving patients, their families or carers and the health care multidisciplinary team.
The views of children and young people must be considered in decisions about attempting CPR.

Young people with capacity are entitled to give consent to medical treatment. Where they lack capacity, it is generally their parents or person designated to have parental responsibility who make decisions on their behalf. Refusal of treatment by competent young people with capacity is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment where it is in the patient's best interest.

Where a competent young person refuses treatment, the harm caused by violating the young person's choice must be balanced against the harm caused by failing to treat.

Agreement will usually be reached about whether CPR should be attempted if the patient suffers respiratory or cardiac failure. If disagreement persists despite attempts to reach agreement, legal advice should be sought.

Parents cannot demand treatment contrary to medical professional judgement, but doctors should try to accommodate parents' wishes as far as is compatible with protecting the child's interests.

A full record of communication with the family should be written in the clinical record on all occasions. 'Do not attempt resuscitation' orders and decisions to withhold or withdraw life sustaining treatment must be clearly recorded in the child's clinical notes together with written account of the process and factors leading to this decision.

The following details must be recorded in the patients' medical notes:

- Date and time of entry
- The decision of "Do Not Attempt Cardiopulmonary Resuscitation"
- Reason for decision
- Record of who was involved in the decision, e.g. patient, family, staff members
- Sign entry, print name and grade
- Consultant in charge of patients care, has the consultant confirmed the decision.

6.8 Patients transferred or discharged

In the event that the patient is transferred to another care facility or is discharged home, health care staff must use appropriate discharge communication channels, including G.P letter, DNACPR form (Acute or Community) to ensure relevant parties are aware of DNACPR decisions.
Details regarding who has been informed of this decision must also be recorded. If the patient was admitted with an advance directive, anticipatory refusal, living will, DNACPR/advance care plan from another organisation, this must remain with the patient on discharge/transfer.

6.9 The following details must be written in the patient's medical notes:

- Date and time of entry
- Capacity decision
- The decision of "Do Not Attempt Cardiopulmonary Resuscitation" or "Not for Further Active Treatment".
- Name the Consultant in charge of the patient's care, has the consultant in charge confirmed the decision?
- The reason for making the decision

- Who else is aware of the decision, e.g. the patient and/or which of the patient's relatives or why the decision has not been discussed with them
- Sign entry and print name and grade
- Bleep number or point of contact
- The Trust DNACPR form must be completed. appendix(1)

A record of the decision must be made in the nursing notes by the most senior member of the nursing team whose responsibility it is to inform the other members of the nursing team.

A DNACPR order should be reviewed regularly by the patient's parent medical team.

Triggers for review should include any request from the patient or those close to them, any substantial change in the patient clinical condition or prognosis and transfer of the patient to a different location.
In the case of End of Life Care for a progressive, irreversible condition there may be little or no need for review of the decision.

An admitting doctor junior in grade to a Consultant, in conjunction with the nursing team can recognise when a DNACPR decision is appropriate. The Consultant in charge of the patient must be contacted to confirm or reject a DNACPR decision. If a DNACPR decision is made then it must be recorded in the medical and nursing notes, as set out in this section. The Consultant in charge must review this decision at the earliest opportunity and must record in the medical notes confirmation or cancellation of the DNACPR decision.

6.10 NCUH Trust Standard DNACPR Form (Appendix 1)

The DNACPR form must be completed for all patients where a DNACPR decision is made. The form is printed in duplicate, when using patient I.D stickers please ensure they are placed on both copies. Once completed the top sheet of the form is placed in the patient notes. The second copy is sent to the site Resuscitation Officer for audit purposes.

Clinical guidance regarding decision making is included on the reverse of the form itself (Appendix 2).

Guidance notes regarding compliant form completion can be found on the reverse of the form (Appendix 3).

IF THE DECISION IS CANCELLED ALL FORMS MUST BE CROSSED THROUGH WITH 2 DIAGONAL LINES IN BLACK INK AND CANCELLED WRITTEN CLEARLY BETWEEN THEM, SIGNED AND DATED BY THE HEALTHCARE PROFESSIONAL CANCELLING THE ORDER

7. TRAINING AND SUPPORT

This Policy will be available on the intranet to support staff responsible for DNACPR decisions.
Staff responsible for dealing with DNACPR orders must complete Mental Capacity Act Level 1 eLearning workbook and / or complete Level 2 learning as indicated on their TNA.

Training is provided for FY1, FY2 and specialist trainees as part of induction and the curriculum programme.
Presentation of Trust DNACPR Policy Compliance - provided annually on both sites, including Question & Answer session.

8. PROCESS FOR MONITORING COMPLIANCE WITH POLICY

The process for monitoring compliance with the effectiveness of the do not attempt resuscitation orders (DNACPR) policy is as follows:

Monitoring/audit arrangements	Methodology	Reporting		
		Source	Committee	Frequency
Audit	Audit of returned DNACPR forms, report compliance	Resuscitation Officers	Resuscitation Committee	6 monthly or more frequently as directed by the Trust
Mandatory Training	Monthly Reports with compliance figures for Mental Capacity Act training	ESR	Work Force Group	Monthly

In addition, DNACPR audit results are presented at Trust Clinical Teaching Sessions.
The hospital Palliative Care Team, are able to support staff and provide education around resuscitation decisions and the Mental Capacity Act.

Wherever the monitoring has identified deficiencies, the following should be in place:

- Action plan
- Progress of action plan monitored by the Trust Resuscitation Committee (minutes)
- Risks will be considered for inclusion in the corporate risk registers

9. REFERENCES

Resuscitation Policy. HSC 2000/28.

Cardiopulmonary Resuscitation – Standards for Clinical Practice and Training. A joint statement from the Royal College of Anaesthetists, Royal College of Physicians of London, The Intensive Care Society and The Resuscitation Council UK (October 2004)

Decisions relating to Cardiopulmonary Resuscitation - Guidance from the British Medical Association, The Royal College of Nursing and the Resuscitation Council UK (3rd edition).October 2014, previously known as the “joint statement”

Mental Capacity Act 2005 Code of Practice (TSO April 2007).

NHSLA Risk Management Standards 2012-13 for Acute Trusts Primary Care Trusts and Independent Sector Providers of NHS Care.

Preliminary statement, Tracey Case Judgement, Resuscitation Council UK (June 2014).

Royal College of Paediatrics and Child Health (2004) Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice 2nd Edition.

Redbridgechildcare.proceduresonline. Withholding or withdrawing life support for children (2017)

UN Convention on the Rights of the Child, Office of the High Commissioner for Human Rights (1989).

10. ASSOCIATED DOCUMENTATION.

MENTAL CAPACITY ACT POLICY

APPENDIX 1 – DNACPR FORM

North Cumbria University Hospitals NHS
NHS Trust

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

Name _____
Address _____
Date of birth _____
NHS or hospital number _____
Consultant _____

Date of DNAR order
/ /

DO NOT PHOTOCOPY

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

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO
If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?" If "YES" go to box 6 YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? YES / NO
If "YES" they must be consulted.

All other decisions must be made in the patient's best interests and comply with current law.
Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate. unsuccessful or not in the patient's best interests:

3 Summary of the communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multi-disciplinary team contributing to this decision:

6 Healthcare professional completing this DNAR order:

Name _____ Position _____
Signature _____ Date _____ Time _____

7 Review and endorsement by most senior health professional:

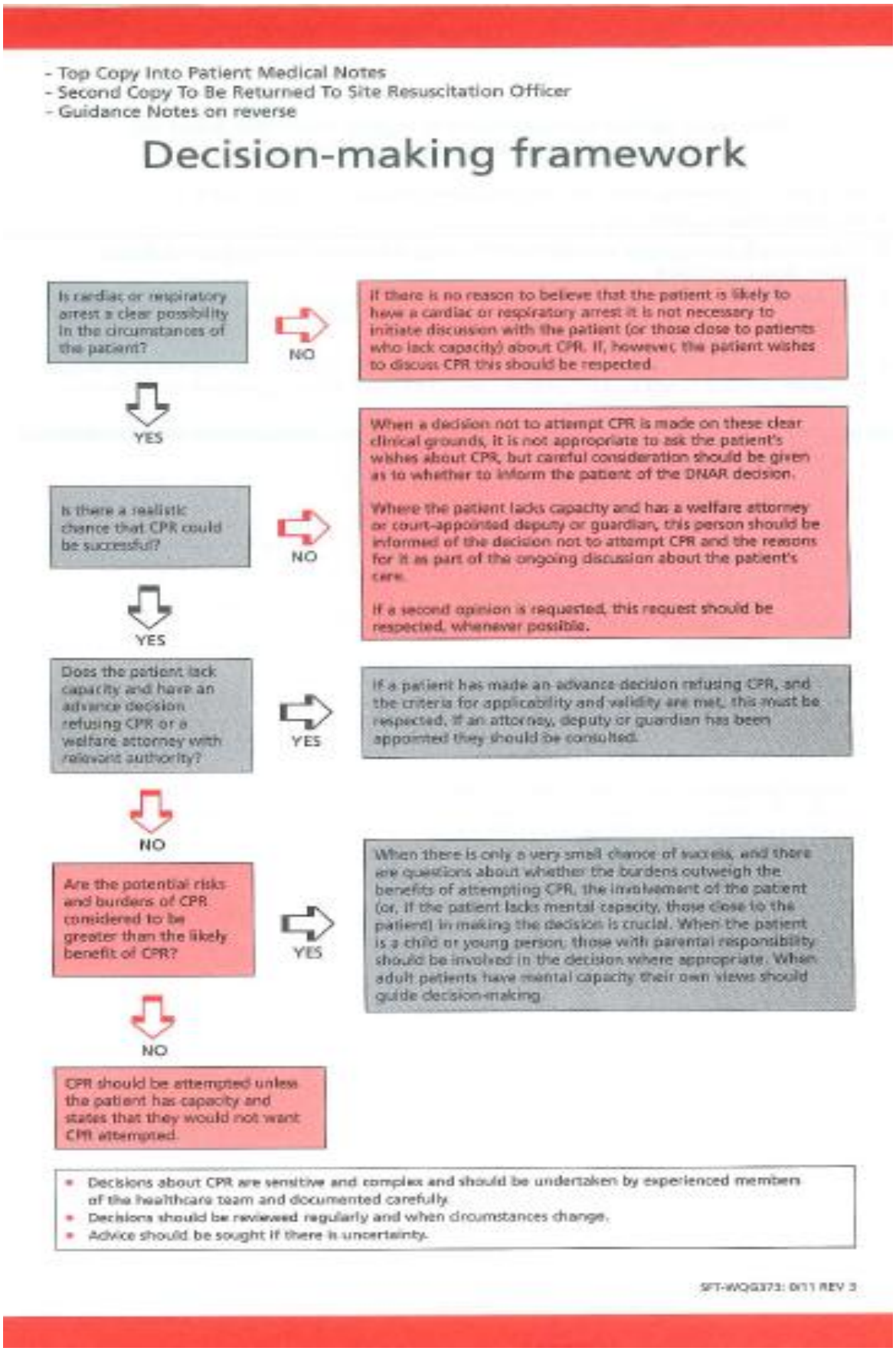
Signature _____ Name _____ Date _____

Review date (if appropriate)

Signature _____ Name _____ Date _____

Signature _____ Name _____ Date _____

APPENDIX 2 – MAKING A CPR DECISION DOCUMENT



APPENDIX 3 – GUIDANCE NOTES FOR DNACPR FORM COMPLETION

This from should be completed in legibly black ball point ink
All sections should be completed

- The patient's full name, date of birth and address should be written clearly.
- The date of writing the order should be entered.
- This order will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified.
- This order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. **Capacity / advance decisions**
   Record the assessment of capacity in the clinical notes. Ensure that any decision is valid for the patient's current circumstances.
   16 and 17-year olds: *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.*
2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests**
   Be as specific as possible.
3. **Summary of communication with patient...**
   State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate. It is not essential to discuss CPR with every patient.
   If a patient is in the final stages of a terminal illness and discussion would cause distress without any likelihood of benefit this situation should be recorded.
4. **Summary of communication with patient's relatives or friends**
   If the patient does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.
   If the patient has capacity ensure that discussion with others does not breach confidentiality.
   State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
5. **Members of multidisciplinary team...**
   State names and positions. Ensure that the DNAR order has been communicated to all relevant members of the healthcare team.
6. **Healthcare professional completing this DNAR order**
   This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.
7. **Review / endorsement...**
   The decision must be endorsed by the most senior healthcare professional responsible for the patient's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.