FAST FIND:

To find DNACPR documentation to be completed for patients within the Trust see ‘GHNHSFT/Y0331/01_18 - Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Decision’

DNACPR decisions should be made in conjunction with the Trust ‘GHNHSFT/Y0643/04_16 - Unwell/Potentially Deteriorating Patient Plan’

Information for patients, family members and carers can be found in Trust information leaflet GHPI0169_06_15 “Cardio-Pulmonary Resuscitation (CPR) which can be found on the Patient Information Leaflet pages of the Trust Internet

This document works in conjunction with the following:

- Planning for your future care
- Advance Care Planning Triggers and Discussion Flowchart
- Resuscitation: Adult ‘In Hospital’ Cardio Pulmonary Resuscitation Procedure
- A1090 Resuscitation of the Newborn Policy
- A0073 Paediatric Inpatient Cardio-Pulmonary Resuscitation (CPR)

The national joint statement on resuscitation is available on the Resuscitation Council UK website at http://www.resus.org.uk/pages/dnacpr.htm (The Trust is not responsible for the content of external websites)

1. INTRODUCTION / RATIONALE

This guideline identifies the key ethical and legal issues that underpin decisions regarding attempting cardiopulmonary resuscitation.

Read this guideline in conjunction with the joint statement from the British Medical Association, Resuscitation Council (UK) (RC) and Royal College of Nursing (‘Decisions relating to Cardiopulmonary Resuscitation’: October 2014). This national document is the primary policy endorsed and fully accepted by the Trust. Its contents should therefore be referred to when any guidance is required. The national joint statement is available at: http://www.resus.org.uk/pages/dnacpr.htm (the Trust is not responsible for the content of external websites).

This local implementation of national policy applies across the multidisciplinary spectrum and it is the responsibility of pertinent staff members to ensure they are familiar with this guideline.

DNACPR decisions must be made in conjunction with the Trust ‘Unwell/Potentially Deteriorating Patient Plan’ (Copyright GHT 2011).
2. DEFINITIONS

<table>
<thead>
<tr>
<th>Word/Term</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR (Cardio Pulmonary Resuscitation)</td>
<td>A combination of artificial ventilation, chest compressions, drug therapy and defibrillation.</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>The sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal, gasping respiration.</td>
</tr>
<tr>
<td>DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)</td>
<td>DNACPR decisions are the overall responsibility of the Consultant in charge of the patient’s care. Attempts at resuscitation will not be commenced when it is felt that a patient would not survive the attempt or when it is the patient’s wishes not to receive CPR. It is emphasised that a DNAR order does not prevent other forms of treatment being provided.</td>
</tr>
<tr>
<td>Unwell/Potentially Deteriorating Patient Plan (UP)</td>
<td>Document which clarifies decision-making in the acutely unwell inpatient through the timely definition of 'ceilings of treatment', thus enabling the escalation of care where appropriate, whilst conversely preventing burdensome and unnecessary interventions where inappropriate.</td>
</tr>
<tr>
<td>Advance Decision to Refuse Treatment (ADRT)</td>
<td>Formal, legally binding document which allows an individual to refuse certain treatments. It does not allow, for a request to have life ended and cannot be used to request medical treatments. An Advance Decision (AD) is very specific and is used in situations when particular treatments would not be acceptable to someone.</td>
</tr>
<tr>
<td>Advance care plan (ACP)</td>
<td>System which can help patients prepare for the future. It gives them an opportunity to think about, talk about and write down their preferences and priorities for their future care, including how they might wish to receive your care towards the end of your life. Anything can be included but it is not legally binding.</td>
</tr>
</tbody>
</table>

3. PURPOSE

- To provide recommendations and guidance on the standards for clinical practice and training required by Trust staff
- To provide a clear definition of terms
- To provide a policy for the making and recording of resuscitation decisions within the Trust, to improve effective communication of such decisions and their rapid, accurate interpretation in the event of cardiac or pulmonary arrest.

4. ROLES AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Post/Group</th>
<th>Details</th>
</tr>
</thead>
</table>
| Resuscitation Committee | - Oversee implementation and review of this guideline  
- The Chair of the Committee is directly responsible for development and review of resuscitation systems with the Lead Resuscitation Officer |
| Resuscitation and Acute Care Response Team Lead | - Ensure safe and effective resuscitation equipment and clinical guidance for the Trust in collaboration with Resuscitation Committee.  
- Communicate changes of policy across the Trust  
- Support/advice on resuscitation issues  
- Investigate resuscitation incidents  
- Introduce current guidelines relating to resuscitation decisions across the Trust  
- Monitor compliance to policy |
| Resuscitation Officers | - Provide training and clinical support in regards to resuscitation decisions in line with current guidelines/legislation  
- Monitoring compliance to policy |
| All doctors, nurses and Allied Health Care Professionals | - Following this and associated policies/procedures  
- Participating in training and instruction  
- Communicate decision to healthcare professionals with direct contact with patient |
| Consultants | - Review acute patients and decide/record ceilings of care on UPP documentation.  
- Signature for DNACPR decisions (yellow sticker) |
5. DO NOT ATTEMPT CPR DECISION MAKING

IMPORTANT NOTE - DNACPR decision making must be made in conjunction with the following:
- Decision Making Framework Flowchart
- GHNHSFT/Y0331/01_18 - Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Decision (‘yellow sticker’)
- GHNHSFT/Y0643/04_16 - Unwell/Potentially Deteriorating Patient Plan

5.1 Information to patients

Written information is available to all patients on admission GHP10169_06_15 “Cardio-Pulmonary Resuscitation (CPR) Information for patients, family members and carers). Their purpose is to explain the process by which decisions are made. Patients should be encouraged to see such information as a routine part of advance care planning to cover all contingencies. This information is intended to reassure patients of their part in decision making and should make it clear that for most patients the question may not arise. All patients and those close to them can ask for time to be set aside to discuss the issues, if they wish, with the Doctors and Nurses caring for them.

Also refer to advance care planning in Section 6 below.

5.2 Responsibility for decision making

The following conditions apply to the decision making process:

- The Consultant in charge of the patient’s care holds overall responsibility for decisions about CPR and DNACPR
- He or she should always be prepared to discuss the decision for an individual patient with other health professionals involved in the patient’s care
- **Shared care between hospital and general practice** - the doctors involved are responsible for discussing the issue with each other. These patients, if admitted to a community hospital, should have the decision properly recorded and conveyed by the GP
- Where the Consultant in charge of the patient’s care is not immediately available, the most senior physician in charge of the patient at that moment is responsible for any decision relating to DNACPR
- The task **must not** be delegated to inexperienced junior doctors
- The National DNACPR Guidance has made provision for senior nursing staff under certain circumstances, e.g. within the community, nursing homes to make DNACPR decisions. Within the Acute Trust such circumstances will not arise as a senior physician will always be available.
- For a person in whom CPR may be successful, when a decision about CPR is 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.
- 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.
- 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.
- If after discussion with the patient (or family members if the patient lacks capacity) the medical team decide that CPR is not clinically indicated, there is no requirement to provide it. The medical team should in these circumstances offer to arrange a second opinion if this is requested. In practice this will mean another consultant, independent from initial medical team who will review the original decision and meet with the patient (or relatives) to discuss it as soon as practically possible.
- 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.
5.3 Temporarily Suspending DNACPR Decisions

It may be necessary to temporarily suspend DNACPR decisions under the following circumstances:

- During certain procedures if the procedure itself could precipitate a cardiopulmonary collapse, e.g. endoscopy, surgery
- General or regional anaesthesia may cause temporary cardiovascular or respiratory instability, as may many routine interventions used during anaesthesia

Under these circumstances, where there is often an easily reversible cause of a cardiorespiratory arrest, survival rates are much higher than those following other causes of in-hospital cardiac arrest. DNACPR decisions should clearly be reviewed in advance of such procedures.

This temporary suspension/decision must be discussed at the WHO pre-operative check list.

5.4 Communicating Decisions

Any DNACPR decision or ceiling of care decisions must be communicated to the entire team of health professionals caring for that patient. **The Doctor making the DNACPR decision must convey this fact to the senior nurse on duty at that time.**

When a patient leaves hospital with a valid DNACPR order in place, ensure this is communicated to the GP/District Nurse/Nursing Home to ensure continuity of care. The following circumstances should trigger this approach:

1. Patient has a valid advance decision to refuse treatment including DNACPR.
2. Patient has advanced progressive illness and resuscitation likely to be medically futile – in such circumstances, repeatedly discussing CPR status may cause unnecessary distress in a setting that clinically is unlikely to change.

Discharge the patient with a completed yellow sticker and UP form.

5.5 Recording Decisions

Record clinical decision making defining the ceiling of care for acute patients on the purple Unwell/Potentially Deteriorating Patient Plan (UP).

- This form is a means of making treatment intention and treatment ceiling explicit in unwell and deteriorating patients, and of maintaining continuity of care.
- If a patient is seen by the Out of Hours Team (medics or ANPs), this should trigger an UP form completion (or UP form review) at the earliest opportunity either before or by the subsequent morning.

If a DNACPR order is made (UP levels 2, 3 and 4), the consultant in charge of the patient (or the most senior physician in charge at that time) is responsible for ensuring that the DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ORDER ‘yellow sticker’ (see Decision Making Framework) is completed and entered into the patient’s medical notes on to the Unwell/Potentially Deteriorating Patient Plan.

**When writing a DNACPR order ‘yellow sticker’ for the medical notes it must be completed with:**

- Patient details
- Date of decision
- Whether this was discussed with patient/next of kin
- The name of the consultant or senior physician (and their designation if not consultant) making the decision, together with their signature if they are available
- The name, designation and signature of the healthcare professional verifying that the DNACPR decision has been made by the consultant or senior physician above when they are not immediately available to sign the ‘yellow sticker’. **This healthcare professional can be a junior doctor or a**
senior nurse involved in the patient’s care. Their signature validates the DNACPR decision.

- If the consultant or senior physician making the DNACPR order does not sign the ‘yellow sticker’ at the time the decision is made, they should do so at the next available opportunity. The DNACPR order however remains valid in the intervening period.
- Reason the DNACPR order was made.

When documenting in the nursing notes that a DNACPR order has been made the written entry must be accompanied by:

- Date and time of DNACPR decision
- Name of physician making the DNACPR order
- Evidence of any discussion with patient/relatives
- Reason the DNACPR order was made
- Signed confirmation of the existence of the DNACPR order
- Name and designation of the nursing signatory (in capitals)
- Date of review of the order (according to the medical notes)

6. ADVANCE DECISIONS TO REFUSE TREATMENT/ADVANCE CARE PLANS

NOTE:
See also
- Advanced Care Planning Triggers/Discussion Tree

The triggers and discussion tree flowchart will help identify patients who may benefit from discussing advance care planning and how to do it. Leaflets are available.

If a patient has an advance care plan, this may include an advance decision to refuse CPR. There is a Gloucestershire advance care planning document which includes a section for ADRT. A valid and applicable advance decision to refuse treatment has the same effect as a decision that is made by a person with capacity; healthcare professionals must follow the decision. Where an ADRT is made, ideally this should have been communicated to all care settings including the acute trust and should be filed within the patients notes.

Patients are encouraged to bring any ADRT documents with them for any hospital attendance.

If an ACP or ADRT is completed when an inpatient, ensure this is filed in the notes and communicated with GP/District nurse etc.

7. TRANSFER OF PATIENT

If the patient is transferred to another ward/hospital, but remains under the care of the Consultant who authorised the DNACPR decision, then the order will remain in place until rescinded by that Consultant. This includes patients who may temporarily leave the hospital, e.g. for a home visit with Occupational Therapy, whose DNACPR order still remains valid for this period.

If the patient is transferred to another Consultant/clinical team, the DNACPR order will remain in place until rescinded by the new Consultant/clinical team.

If a patient arrives from another hospital outside the Trust with a valid DNACPR order, then this should remain valid until it is reviewed by the Consultant or most senior physician in charge of the patient’s care at that time. This decision should be reviewed at the earliest opportunity.

Please ensure that decisions are communicated to day units including chemotherapy/radiotherapy/Edward Jenner Unit/Dialysis/Ambulatory Day Unit. These units will disseminate this information within their setting and are encouraged to seek information relating to DNACPR.
8. REVIEW OF CEILINGS OF CARE AND DNACPR DECISION

8.1 Reviews

A fixed review date is not recommended. This decision should be indefinite unless:

- a definite review date is specified
- there are changes in the patient’s condition and CPR may now be successful
- the patient’s expressed wishes change and CPR may now be successful

It is timely to remind those present at Consultant ward rounds that a Ceiling of Care/DNACPR order is in place and that any of the points above may now apply.

Where there is any entry made in the clinical notes during the Consultant ward round, the DNACPR order remains valid (even if not mentioned) UNLESS there is a clear instruction that the order has been cancelled.

8.2 Cancelling a DNA CPR Order

When a DNA CPR order is cancelled the following must be adhered to:

- Place two bold lines diagonally across the DNACPR ‘yellow sticker’
- Write ‘Cancelled’ boldly between the two lines
- A senior physician must sign clearly in between the two lines
- Write date and time clearly between the two lines

When the ceiling of care level is changed (either increased/ decreased), cross through the purple UP form (as per yellow sticker cancellation) and complete a new form, clearly documenting the revised level of care.

9. CHILDREN AND YOUNG PEOPLE

Read this section in conjunction with the national guidance mentioned previously, the Royal College of Paediatrics and Child Health document, Withholding or Withdrawing Life Saving Treatment in Children – A Framework for Practice and the Trust Advanced Care Plan for Children.

As with the care of adults, there are circumstances when it may not be in the child’s best interest to prolong life. The principles stated in this document also apply to the care of children. Parents must always be participants in the decision-making process regarding cardiopulmonary resuscitation. The child should be involved to a degree appropriate for their age, experience or their illness and condition and their views should be taken into account wherever possible.

In emergencies, it is often doctors in training who are called to resuscitate children and newborn babies. Rigid rules should be avoided and resuscitation efforts may need to be continued until a senior or more experienced paediatric doctor arrives.

Ensure any DNACPR decision for a child is documented in the patient’s notes in accordance with this document and the Advanced Care Plan for Children.

9.1 DNACPR issues in neonatal care

Imminent, extreme premature delivery and the presence of congenital abnormalities incompatible with survival (e.g. anencephaly) are clinical examples of situations in neonatal practice where resuscitation attempts should be discussed.

The following applies to the decision making and documentation process:
Decisions regarding whether resuscitation will be attempted at birth should be fully discussed with the parents, the health care team looking after the mother and Consultant Paediatrician.

Ensure the outcome of the discussion with the parents and the agreed plan of action is fully documented in the maternal notes.

File a copy of the documentation of this discussion in the “expected deliveries” folder on the Neonatal Unit at GRH.

Send further copies to all community staff (e.g. midwives, health visitor) who are likely to be looking after these infants.

10. **MENTAL CAPACITY ACT ISSUES**

Any patients for whom there are issues regarding their Mental Capacity should have any DNACPR decisions discussed and implemented or in accordance with the National Guidance published in the BMA, RC (UK) and RCN document.

11. **TRAINING**

- All Clinical staff, across all directorates will receive training at Clinical Induction and receive an annual update.
- DNACPR and the UP form training are incorporated into many different courses, awareness via reading policy on-line or circulation of hard copies of document. Advance Care Planning training.

12. **MONITORING OF COMPLIANCE**

<table>
<thead>
<tr>
<th>Monitoring requirements and methodology</th>
<th>Frequency</th>
<th>Further actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of DNACPR orders via the UP Trial (Oncology – General Surgery 2010-2012) by Resuscitation Lead</td>
<td>During and after 2-year trial (NCEPOD recommendation June 2012)</td>
<td>Report to Resuscitation Committee</td>
</tr>
<tr>
<td>Review of DNACPR documentation and retrospective joint audit by Clinical Audit and Resuscitation Department</td>
<td>Annual</td>
<td>Report to Resuscitation Committee</td>
</tr>
<tr>
<td>Review of all 2222 calls and relevant health care records by Resuscitation Officers</td>
<td>Ongoing</td>
<td>Report to Resuscitation Committee</td>
</tr>
</tbody>
</table>

13. **REFERENCES**

The Trust is not responsible for the content of external websites

Resuscitation Council and Royal College of Nursing (2014). Decisions relating to cardiopulmonary resuscitation. [www.resus.org.uk](http://www.resus.org.uk)


[GHNHST National Early Warning Score (NEWS) and Assessment of Acutely Ill Adult Patients Protocol](http://www.ncepod.org.uk/2012cap.htm)
General Medical Council (2010). Treatment and Care towards the end of life.
http://bja.oxfordjournals.org/content/112/6/1123.3.extract

## DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

### DOCUMENT PROFILE

<table>
<thead>
<tr>
<th>REFERENCE NUMBER</th>
<th>A0037</th>
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<td>VERSION</td>
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<tr>
<td>QUALITY ASSURANCE GROUP</td>
<td>Deteriorating Patient and Resuscitation Committee</td>
</tr>
<tr>
<td>AUTHOR</td>
<td>Janice Allen, Resuscitation Officer, Resuscitation Committee</td>
</tr>
<tr>
<td>ISSUE DATE</td>
<td>May 2018</td>
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<tr>
<td>REVIEW DATE</td>
<td>May 2021</td>
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<td>OTHER APPROVING GROUPS</td>
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| APPROVAL AND RATIFICATION DETAILS / DATES | Guideline Approval: Deteriorating Patient and Resuscitation Committee E-Approved 24th April 2018 (discussed at meeting on 16th March 2018)  
TPAG Ratification: 25th April 2018 |
| CONSULTEES       | Membership of the Deteriorating Patient and Resuscitation Committee |
| DISSEMINATION DETAILS | Upload to Policy Site; Policy Monthly Update; dissemination via divisions |
| KEYWORDS         | Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), Advance Care Planning |

### RELATED TRUST DOCUMENTS

- Decision Making Framework Flowchart; GHNHSFT/Y0331/01_18 - Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Decision; GHNHSFT/Y0643/04_16 - Unwell/Potentially Deteriorating Patient Plan; Advanced Care Planning Triggers / Discussion Tree;

### OTHER RELEVANT DOCUMENTS

- Resuscitation Procedure / Guideline - Adult and Children, GHNHST National Early Warning Score (NEWS) and Assessment of Acutely Ill Adult Patients Protocol

### EXTERNAL COMPLIANCE STANDARDS AND/OR LEGISLATION

- Resuscitation Council UK Guidelines
- NCEPOD