



---

**Policy:** Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)  
**Policy number:** 2.08

---

**This policy is based on the South East Coast Strategic Health Authority Policy  
Do Not Attempt Cardiopulmonary Resuscitation Principles (DNACPR) <sup>1</sup>**

### **1. Policy Statement**

There is evidence to suggest that, for terminally ill patients, the harms of cardiopulmonary resuscitation (CPR) are likely to far outweigh the possible benefits. Evidence indicates that where cardiac arrest occurs out of hospital, the survival rate to discharge is at best 5-10%<sup>2,3</sup>.

Hospice in the Weald (HitW) has no facilities for advanced life support. A principal focus of our care is to try to ensure dignity throughout the dying process and affirm death as a natural part of life. The decision to transfer patients for active resuscitation is a multi disciplinary one and is decided on an individual basis. This decision should be made explicit to all health care professionals concerned with caring for that patient and the wishes of the individual lie at the heart of this decision.

Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or those close to the patient. It is good clinical practice to discuss major decisions about care with patients and / or their families and this includes decisions about DNACPR. There should always be a presumption in favour of patient involvement and there need to be very convincing reasons not to involve the patient. However it is inappropriate 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<sup>4,5</sup>.

### **2. Related policies, guidelines and procedures**

Policy: Advance Decisions to Refuse Treatment 2.21  
Guideline: Resuscitation (AED)

### **3. Responsibility and Accountability**

Policy formulation: Helen McGee, Medical Director  
Policy review: Hanie David, Lead Clinical Nurse Specialist  
Lisa Hatcher, Matron  
Clinical Approval: Helen McGee, Medical Director  
Compliance: All clinical staff

### **4. Relevant Dates**

Policy originated:	June 2006
Last Review Date:	November 2014
This review date	April 2016
Next Review Date:	April 2020

## 5. CPR Decision Making

The overall responsibility for DNACPR decisions rests with the consultant or GP in charge of the patient's care, in conjunction with the senior nurse involved in the care of the patient<sup>5</sup>. However they may delegate this responsibility to another registered medical practitioner or an experienced nurse who has undertaken appropriate training. Decisions should be made by the most senior member of the clinical team available and ratified by the consultant or GP or their deputy at the earliest possible opportunity. Wherever possible, a decision should be agreed by two senior members of the health care team responsible for the patient's care and treatment.

Until the situation has been reviewed Acute Trusts will recognise and comply with any DNACPR orders completed by senior, accredited community staff made on behalf of patients who are then admitted to an acute hospital.

There are five different situations in which a DNACPR decision needs to be considered depending on the likelihood of success of CPR and the capacity of the patient:

**i. When attempts at CPR have a reasonable chance of success and the patient has capacity for decision making.**

- It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer a cardiorespiratory arrest.
- Patients should however be given as much information as they wish about their situation including information about resuscitation. It is the professional's responsibility to find out how much the patient wishes to know or can understand.
- Written information on CPR should be available for all patients and their families.
- If a patient with capacity refuses CPR this must be respected.
- Patients should be encouraged to complete an Advanced Decision to Refuse Treatment (ADRT) or appoint a Lasting Power of Attorney for Health and Welfare (LPA) if they have specific requests regarding refusal of potential future treatments as CPR decision forms are not legally binding<sup>5</sup>.

**ii. When attempts at CPR have a reasonable chance of success and the patient is assessed as not having capacity for decision- making.**

The decision remains the responsibility of the consultant or GP responsible for the patient's care taking into account the following:

- If a patient lacking capacity has a valid and applicable advance decision refusing CPR this should be respected.
- Any properly appointed Lasting Power of Attorney for health and welfare should be consulted.
- In the absence of these, those close to the patient should be involved in discussions to explore the patient's wishes, feelings, beliefs and values.
- For patients who are unbefriended an Independent Mental Capacity Advocate (IMCA) must be involved.

- Relatives or friends should never be placed in a position in which they feel they are making a DNACPR decision for the patient unless they have been appointed as the patient's personal welfare attorney under a Lasting Power of Attorney (LPA)<sup>6</sup>.
- iii. When attempts at CPR have little or no chance of success and the patient has capacity for decision-making.**
- Whilst patient's informed views are of great importance, where the expected benefit of attempted CPR may be outweighed by the burdens the GMC has stated that "there is no obligation to give treatment that is futile or burdensome." This applies to CPR<sup>7</sup>.
  - If there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. When a person is in the final stages of an incurable illness and death is expected within a few hours or days, in almost all cases CPR will not be successful<sup>5</sup>.
  - If CPR is futile, HitW will support a justifiable and appropriately documented decision of a healthcare professional not to attempt CPR.
  - There should be a presumption in favour of patient involvement and there need to be convincing reasons not to involve the patient in DNACPR decisions. Where a patient has made it clear they do not wish to talk about dying or discuss their end of life care, this must be respected.
  - All decisions must be clearly documented in the electronic care records and any reason for not discussing it with the patient, clearly stated.
- iv. When attempts at CPR have little or no chance of success and the patient lacks capacity for decision making.**
- The decision remains the responsibility of the consultant or GP responsible for the patient's care.
  - In order to make a fully informed decision, where it is both practicable and appropriate, they must discuss the patient's situation and the decision with those close to the patient (subject to any confidentiality restrictions expressed if, and when, the patient had capacity).
  - Where both practicable and appropriate, they should not delay contacting those close to the patient in order to do this. Of note, in the recent judgment it was stated by the judge that "a telephone call at 3.00 am may be less than convenient or desirable than a meeting in working hours, but that is not the same as whether it is practicable".
  - When it is not possible to contact those close to the patient immediately and an anticipatory decision about CPR is needed in order to deliver high-quality care, that decision should be made in accordance with the relevant legislation.
  - For unbefriended patients there is no need to appoint an IMCA<sup>5</sup>
- v. When no CPR decision has been taken and the situation is clearly palliative.**
- There may be occasions when due to unavoidable circumstances a Health Professional who is unable to contact a doctor immediately, makes a decision based on their knowledge of the patient, the patient's circumstances and the patient's wishes, not to commence CPR.
  - HitW will support any appropriate decisions made by the health professional in these circumstances. However such decisions must be incontrovertible and very clearly documented.
  - This only applies in emergency situations and health professionals should do everything possible to contact either the GP or consultant or their deputy. If they are unable to do so then they must document the reasons for this in the patient's medical records.

## **6. Discussion of CPR decisions**

- For any patient a decision needs to be made regarding:
  - Who to include in the discussion about CPR
  - What to cover in the discussion about CPR
- It is not necessary to burden a patient or relevant others with a CPR discussion where a cardiac or respiratory arrest cannot be anticipated.
- For all patients for whom CPR is felt not to be appropriate this should be discussed with the patient unless there are convincing reasons not to. Where a patient has made it clear they do not wish to talk about dying or discuss their end of life care, this must be respected. It is important to ensure that families and those close to the patient are aware of the DNACPR decision.
- If a patient's family members are not available immediately then a timely decision should still be made and then communicated to the family at the earliest opportunity. It should be made clear to those close to the patient that their role is to help inform the decision-making process, rather than being the final decision-makers.
- All decisions must be clearly documented in the electronic care record. This will often require documentation in the electronic care record of detail beyond the content of the DNACPR form.
- In any situation, a clinician who makes a conscious decision not to inform a patient of a DNACPR decision, as they believe that informing the patient is likely to cause them harm, should document clearly their reasons for reaching this decision.
- Information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team.
- A decision not to attempt CPR applies only to CPR and inclusion of decisions relating to CPR as part of an advance care plan or a treatment escalation plan may help to emphasise which other treatment options are and are not appropriate for each individual. The responsible health professional should initiate the process at the appropriate time. This may be delegated to other members of their team including senior nurses and other health care professionals who have been suitably trained.

## **7. Requests for CPR in situations where it will not be successful**

- Patients have no legal right to treatment that is clinically inappropriate. If the healthcare team has good reason to believe that CPR will not re-start the heart and breathing this should be explained to the patient in a sensitive but unambiguous way. These decisions and discussions are not easy and should be undertaken by senior clinicians whenever possible.
- If the patient doesn't accept the decision, a second opinion should be offered. However there is no legal obligation to offer a second opinion in cases where the patient is being treated by a multi-disciplinary team, all of whom take the view that a DNACPR decision is appropriate

## **8. Recording and Communicating DNACPR decisions**

If a 'DNACPR' decision is made, the senior health care professional must complete the DNACPR form which has a high visibility red border (**Appendix 1**). This is the only valid DNACPR document; it requires an ink signature and must not be copied.

This is a standard form recognised by all Trusts, Out of Hours services and Hospices across the former South East Coast NHS region.

A DNACPR order documented on the standard red form is therefore valid in all health care settings including during transfer from one setting to another across the former South East Coast NHS region. It should be respected by all healthcare professionals.

The red DNACPR form is the active form and should stay with the patient or travel with the patient on transfer to other care settings including on discharge home so that the decision is backed up by the visible presence of the form.

The completed red form should be placed in the front of the patient care record appropriate to the care setting such as hospital, hospice or community nursing or care home care records.

Completing a red DNACPR form on the carbon pad also creates a grey Decision Record (**Appendix 2**) which can be photocopied or faxed if needed and is stored in the patient's notes.

While only the red form is the active version, the presence of a grey decision record form in the care record should inform the healthcare professionals' decision making if the Red form is not available at a future time.

If the red form is signed in section 6 under delegated authority by senior medical practitioner who is not ultimately responsible for the patient's care (e.g. doctors on call, visiting GP, clinical nurse specialist and sisters with appropriate competencies), the form then needs the endorsement of the Consultant, GP or senior nurse responsible for the care of the patient as soon as is practically possible by counter-signing the form in section seven.

If the GP, Consultant or appropriately trained senior nurse signing the DNACPR form feels that it will be clinically appropriate to review the decision, they must enter a review date and will therefore need to make appropriate arrangements for this review to take place. The decision should also be reviewed if there are changes in the patient's condition and wishes. If a review is felt to be unnecessary then this can be indicated by writing "N/A" in the review box at the bottom of the form.

The DNACPR decision should be communicated to other healthcare professionals involved in the patient's care (eg GP, hospital teams, Out of Hours services and the ambulance service) in a timely manner. This can be achieved by documenting it in clinical letters and recording on shared electronic health records. The grey Decision Record can also be copied and sent electronically to healthcare professionals. It is good practice to ensure the patient's GP/Consultant is informed at the earliest opportunity.

The healthcare professional who has initiated the decision, must record the decision making process in the patient's electronic health record and ensure their DNACPR status is complete.

### **In-Patient Unit (IPU)**

If the patient is for CPR then

- '999' should be written in red against the patient's name on the white board in the IPU ward office.

If the patient is not for CPR then

- The red DNACPR form should be kept in the front of the patient's nursing records folder whilst they are on the IPU.
- The grey Decision Record should be placed in their paper notes.
- The patient should be given their red DNACPR form on discharge or when the patient is transferred to another care setting (e.g. hospital transfer for admission or outpatient attendance via ambulance).

In all cases

- The CPR status on the electronic care records should be completed or updated.
- The decision should be handed over from one nursing shift to the next as a matter of routine practice.
- The resuscitation status of the patient should be documented in their discharge letter which should be sent to the patient's GP on the day of discharge and copied to consultants and other healthcare professionals involved in that patient's care.

### **Hospice in the Home (HitH) and Hospice Day Service (HDS)**

- Patients should be given the red DNACPR form to keep with them and the grey copy is kept at the Hospice.
- Other healthcare professionals involved in the patient's care should be notified as above.
- The CPR status on electronic care record should be completed or updated.
- The Out Of Hours Handover Form should be updated and faxed to the out of hours and ambulance services.
- In Hospice Day Service (HDS) the resuscitation it is displayed on the electronic board in the HDS office which patients are for active resuscitation.

## 9. Transferring patients

On transfer from one care setting to another the active red form should travel with the patient. The grey DNACPR Decision Record should remain in the originator's notes.

Forms completed in hospital or hospices should be reviewed before the patient is discharged to the community.

## 10. Cancelling DNACPR decisions

If the 'DNACPR' order is cancelled the form should be removed from the notes, crossed through with two lines and highlighted with the instruction 'This order is cancelled', signed, dated and filed normally. A suitable entry must also be made in the patient's electronic care record and all relevant agencies informed. Any copies of the order should also be crossed through, signed and dated when the agencies are informed of the cancellation.

## 11. Training

Experienced nurses who are required to take on this extended role must undertake training and complete the competency assessment in line with those agreed by the NHS South East Coast End of Life (EOL) Clinical Advisory Group. (**Appendix 3**)

## 12. References

1. NHS South East Coast Do Not Attempt Cardio Pulmonary Resuscitation Principles (DNACPR), July 2010 accessed at [http://gp.westernsussexhospitals.nhs.uk/wp-content/uploads/gpsiteweb/NHS\\_South\\_East\\_Coast\\_DNAC~\\_principles\\_Nov\\_2010-AssetID=356942&type=full&servicetype=Attachment.pdf](http://gp.westernsussexhospitals.nhs.uk/wp-content/uploads/gpsiteweb/NHS_South_East_Coast_DNAC~_principles_Nov_2010-AssetID=356942&type=full&servicetype=Attachment.pdf) (04.12.14)
2. Nolan J et al. Outcome following admission to UK intensive care units after cardiac arrest: a secondary analysis of the ICNARC Case Mix Programme Database. *Anaesthesia* 2007; 61 (12) 1207-1216
3. Perkins GD, Cooke MW. Variability in cardiac arrest survival : the NHS Ambulance Service Quality Indicators. *Emerg Med J* 2012;29:3-5
4. Tracey, R (On the Application Of) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822 (17 June 2014) accessed at <http://www.bailii.org/ew/cases/EWCA/Civ/2014/822.html> (04.12.14)
5. Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2014 accessed at <https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr-new-statement/> (11.2015))
6. Mental Capacity Act 2005 accessed at <http://www.legislation.gov.uk/ukpga/2005/9/contents> (12.10.10)
7. GMC Guidance 2010. Treatment and care towards the end of life: good practice in decision making. Accessed at [http://www.gmc-uk.org/static/documents/content/End\\_of\\_life.pdf](http://www.gmc-uk.org/static/documents/content/End_of_life.pdf) (4.12.14)

## DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over



Tel: 01892 820500

Name _____
Address _____
Date of birth _____
NHS & Hospital numbers _____ / _____

Date of DNACPR order:

/ /
-----

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

<b>1</b>	<p><b>Does the patient have capacity to make and communicate decisions about CPR?</b> If "YES" go to box 2</p> <p>If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If "YES" go to box 8</p> <p>If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted.</p> <p>All other decisions must be made in the patient's best interests and comply with current law. Go to box 2</p>	<input type="checkbox"/> YES / <input type="checkbox"/> NO  <input type="checkbox"/> YES / <input type="checkbox"/> NO  <input type="checkbox"/> YES / <input type="checkbox"/> NO
----------	--	--

<b>2</b>	<p><b>Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:</b></p>
----------	--


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

<b>4</b>	<p><b>Summary of communication with patient's relatives or friends:</b></p>
----------	---

<b>5</b>	<p><b>Names of members of multidisciplinary team contributing to this decision:</b></p>
----------	---

<b>6</b>	<p><b>Healthcare professional completing this DNAR order:</b></p>		
Name _____	Position _____		
Signature _____	Date _____	Time _____	

<b>7</b>	<p><b>Review and endorsement by most senior health professional:</b></p>		
Signature _____	Name _____	Date _____	
	<input style="width: 100%;" type="text" value="Review date (if appropriate)"/>		
Signature _____	Name _____	Date _____	
Signature _____	Name _____	Date _____	

<b>DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION DECISION RECORD</b>	
<b>Adults aged 16 years and over</b>	
<p>Name _____</p> <p>Address _____</p> <p>Date of birth _____</p> <p>NHS &amp; Hospital numbers _____ / _____</p>	 Tel: 01892 820500 Date of DNACPR order: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto; display: flex; justify-content: space-around; align-items: center;"> <span>/</span> <span>/</span> </div>
<p style="text-align: center;">In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.</p>	
<p><b>1 Does the patient have capacity to make and communicate decisions about CPR?</b> If "YES" go to box 2</p> <p style="text-align: right;"><input type="checkbox"/> YES / <input type="checkbox"/> NO</p> <p>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</p> <p style="text-align: right;"><input type="checkbox"/> YES / <input type="checkbox"/> NO</p> <p>If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted.</p> <p style="text-align: right;"><input type="checkbox"/> YES / <input type="checkbox"/> NO</p> <p>All other decisions must be made in the patient's best interests and comply with current law. Go to box 2</p>	
<p><b>2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:</b></p> <div style="border: 1px solid black; height: 40px;"></div>	
<p><b>3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:</b></p> <div style="border: 1px solid black; height: 40px;"></div>	
<p><b>4 Summary of communication with patient's relatives or friends:</b></p> <div style="border: 1px solid black; height: 40px;"></div>	
<p><b>5 Names of members of multidisciplinary team contributing to this decision:</b></p> <div style="border: 1px solid black; height: 30px;"></div>	
<p><b>6 Healthcare professional completing this DNAR order:</b></p> <p>Name _____ Position _____</p> <p>Signature _____ Date _____ Time _____</p>	
<p><b>7 Review and endorsement by most senior health professional:</b></p> <p>Signature _____ Name _____ Date _____</p> <div style="border: 1px solid black; width: 150px; height: 15px; margin: 5px auto; display: flex; align-items: center; justify-content: center;">             Review date (if appropriate)           </div> <p>Signature _____ Name _____ Date _____</p> <p>Signature _____ Name _____ Date _____</p>	



## **DNACPR Discussion Training Programme for Senior Nurses at Hospice in the Weald**

### **Competency Document**

The aim of undertaking this training programme is to develop the practice of experienced health care professionals (HCPs), so that they can discuss decision making for DNACPR with patients and significant others. HCPs will utilise a framework of skills and competency that reflect sound clinical knowledge and judgement.

Competency should be achieved by individuals as soon as possible after completion of the training programme. It is expected that this will have occurred 3-6 months after attending.

The individual will have demonstrated competency at the level of an independent practitioner to an assessor before being deemed able to practise independently. This assessor will usually be their line manager or another member of the Senior Nurse Team.

The individual is responsible for arranging time with their assessor to undertake appropriate observation in clinical practice.

The assessor will recognise if the performance is satisfactory or not; and if any further experience is required.

The competency and assessment documentation is to be retained as evidence of an individual's competency.

### **Acknowledgements**

Competences have been developed by Nikki Le Prevost on behalf of the Bexley Palliative Care Strategy Group with reference to the following documents:

The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process 2004 DOH; CHS48 Communicate significant news to individuals, Skills for Health 2007; Decisions Relating to Cardiopulmonary Resuscitation – model information leaflet BMA.



<b>DNAR COMPETENCIES</b>						
<b>SURNAME</b>						
<b>FORENAME</b>						
<b>CLINICAL SETTING</b>	A&E	GP Surgery	Community	Care Home	Hospice	Hospital
<b>ASSESSOR'S POSITION</b>	Consultant	GP	SpR	CNS	Nurse Consultant	Lecturer Practitioner

<b>COMPETENCY</b>	<b>OUTCOME/ EXPECTATION</b>	<b>DATE</b>	<b>PRACTITIONER/ ASSESSORS SIGNATURE</b>
<b>LEGISLATION</b>			
Knowledge of national and local guidance	Is able to refer to national and local guidelines and policies		
Records and documents information clearly, concisely and accurately	Demonstrates appropriate record keeping and completion of documentation  Evidences awareness of keeping completed form in an appropriate place.		

<b>COMPETENCY</b>	<b>OUTCOME/ EXPECTATION</b>	<b>DATE</b>	<b>PRACTITIONER/ ASSESSORS SIGNATURE</b>
<b>PROFESSIONALISM</b>			
Reflection on own practice	Recognises own learning needs and identifies how to meet these  Takes responsibility for attending appropriate training		

Appendix 3 continued

COMPETENCY	OUTCOME/ EXPECTATION	DATE	PRACTITIONER/ ASSESSORS SIGNATURE
<b>COMMUNICATION SKILLS</b>			
Communicates skilfully with the patient and/ or proxy	Creates awareness of the purpose of the discussion		
Communicates skilfully about patient wishes and decisions	<p>Demonstrates an appropriate approach to enable ease of discussion</p> <p>Demonstrates the use of language which is easily understood</p> <p>Shows ability to use a wide range of communication skills, including open questions, clarification and summarising</p> <p>Responds to questions honestly and accurately and provides opportunity for questions</p> <p>Allows for the expression of emotion</p>		
Communicates with the multi-professional team	<p>Demonstrates appropriate consultation with team members</p> <p>Shows awareness of the need to transfer decision documentation with the patient between care settings</p>		

Appendix 3 continued

COMPETENCY	OUTCOME/ EXPECTATION	DATE	PRACTITIONER/ ASSESSORS SIGNATURE
<b>CLINICAL JUDGEMENT</b>			
Reaches a decision regarding DNAR with patient and/ or proxy	Demonstrates review of individuals medical history to understand current situation  Assesses the patient's capacity to make informed decision		
<b>EQUALITY AND DIVERSITY</b>			
Acknowledges the influence of culture, ethnicity and faith on patients and families	Demonstrates understanding of different cultures, faiths and ethnicity which may affect patients decision making		