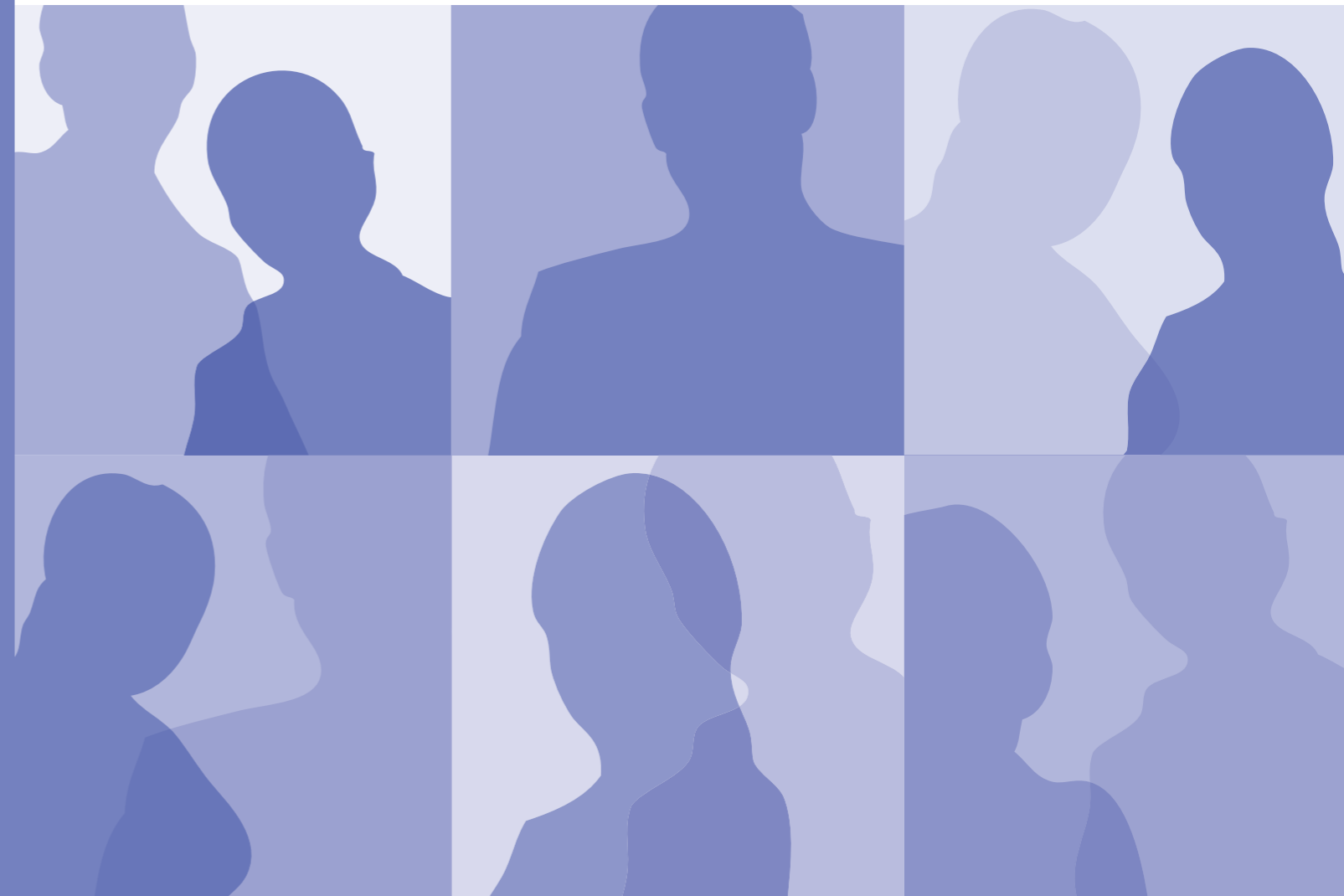


**Unified
Do Not Attempt
Cardiopulmonary Resuscitation
(DNACPR)
Adult Policy**



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1 Introduction

Survival following Cardio Pulmonary Resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Although CPR can be attempted on any person prior to death, there comes a time for some people when it is not in their best interests to do so. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity.

2 Policy Statement

The South Central Strategic Health Authority (SCSHA) DNACPR policy will ensure the following:

- 2.1 All people are presumed to be "For CPR" unless a valid DNACPR decision has been made and documented, or an Advance Decision to Refuse Treatment (ADRT) prohibits CPR.
- 2.2 All DNACPR decisions are based on current legislation and guidance.
- 2.3 When CPR would not restart the heart and breathing of the individual it will not be attempted.
- 2.4 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) although people have a right to refuse to have these discussions.
- 2.5 A standardised documentation form for adult DNACPR decisions will be used (see appendix 1).
- 2.6 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.
- 2.7 The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.
- 2.8 Training will be available to enable staff to meet the requirements of this policy.
- 2.9 This policy has been reviewed by legal services.

3 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
 - provide benefits that are not outweighed by burden.
- 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 options.

4 Scope

- 4.1 This policy applies to all of the multidisciplinary healthcare team involved in patients care across the range of settings within the SCSHA.
- 4.2 This policy can be applied to all individuals over the age of 18.

5 Definitions

- 5.1 **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.
- 5.2 **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.
- 5.3 **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.
- 5.4 **Mental Capacity** - An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary.

Individuals that lack capacity will not be able to:

- understand 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.

- 5.5 **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.
- 5.6 **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.
- 5.7 **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.
- 5.8 **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.
- 5.9 **A Court-appointed deputy** 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.

6 Legislation and Guidance

Legislation

6.1.1 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.

6.1.2 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).

6.1.3 Clinicians have a professional duty to report deaths to the Coroner and should be guided by local practice as to the circumstances in which to do so. However, deaths should *always* be reported where the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.

For more information see:

Coroners, post-mortems and inquests : Directgov - Government, citizens and rights
www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

6.1.4 Equality Impact Assessment (EIA) (see Appendix 4). An example has been completed by the CSHA; each organisation will need to carry out an EIA.

Guidance

6.2 Resuscitation Council (UK):

- recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
- decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing. (October 2007, updated November 2007).

Decisions Relating to Cardiopulmonary Resuscitation
www.resus.org.uk/pages/dnar.pdf

7 Roles and Responsibilities

7.1 This policy and its forms/appendices are relevant to all clinical staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed by the local authority or employed privately by an agency.

7.2 The decision to complete a DNACPR form should be made by a Consultant (or Doctor who has been delegated the responsibility by their employer) / General Practitioner / Registered Nurse with Accreditation.

7.3 The individual should, inform where able, those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

7.4 The Chief Executive of South Central Strategic Health Authority is responsible for:

- ensuring that this policy adheres to statutory requirements and professional guidance
- supporting unified policy development and the implementation for other organisations
- ensuring that the policy is monitored
- reviewing of policy every two years.

7.5 Chief Executives of provider organisations are responsible for:

- governance compliance for the policy and procedure
- procuring and / or providing legal support.

7.6 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 understand 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 a nominated Director at the SCSHA
- ensure that DNACPR forms, leaflets and policy are available as required.

7.7 Consultants / General Practitioners are **responsible for making DNACPR decisions:**
 They must:

- be competent to make the decision
- must verify any decisions made by junior medical staff / Registered Nurses with Accreditation at the earliest opportunity
- document the decision (see 8.6)
- make every effort to 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.

7.8 Clinical staff delivering care must:

- adhere to the policy and procedure
- notify line manager of any training needs
- sensitively enquire to the existence of a DNACPR or a ADRT
- check the validity of any decision
- notify other services of the DNACPR decision or an ADRT on the transfer of a person
- participate in the audit process.

7.9 Commissioners and Commissioned Services must:

- ensure that services commissioned implement and adhere to the policy and procedure
- ensure that pharmacists, dentists and others in similar healthcare occupations are aware of this policy.

- 7.10 The Ambulance service staff must:
- adhere to the policy and procedure
 - notify their line manager of any training needs
 - ensure that they are aware of the existence of a DNACPR decision or an ADRT, either via the individual / relatives or the health care professional requesting assistance
 - check the validity of any decision
 - participate in the audit process.
- 7.11 In-patient Specialist Palliative Care staff must:
- include information regarding a DNACPR decision in pre-admission documentation
 - cascade all decisions to staff
 - adhere to the policy and procedure
 - notify their line manager of any training needs
 - ensure that they are aware of the existence of a DNACPR decision or an ADRT, either via the individual / relatives or the health care professional requesting assistance
 - check the validity of any decision
 - participate in the audit process.

8 Process

- 8.1 For the majority of people receiving care in hospital or community setting, the likelihood of cardiopulmonary arrest (cessation of breathing and heartbeat) is small, therefore, no discussion of such an event routinely occurs unless raised by the individual.
- 8.2 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 (RC) (UK) unless a valid DNACPR decision or an ADRT is in place and made known.
- 8.3 In the event of a clinician finding a person dead and 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. 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?
 - is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading if futile?
 - 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.

BMA/RCN/RC (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

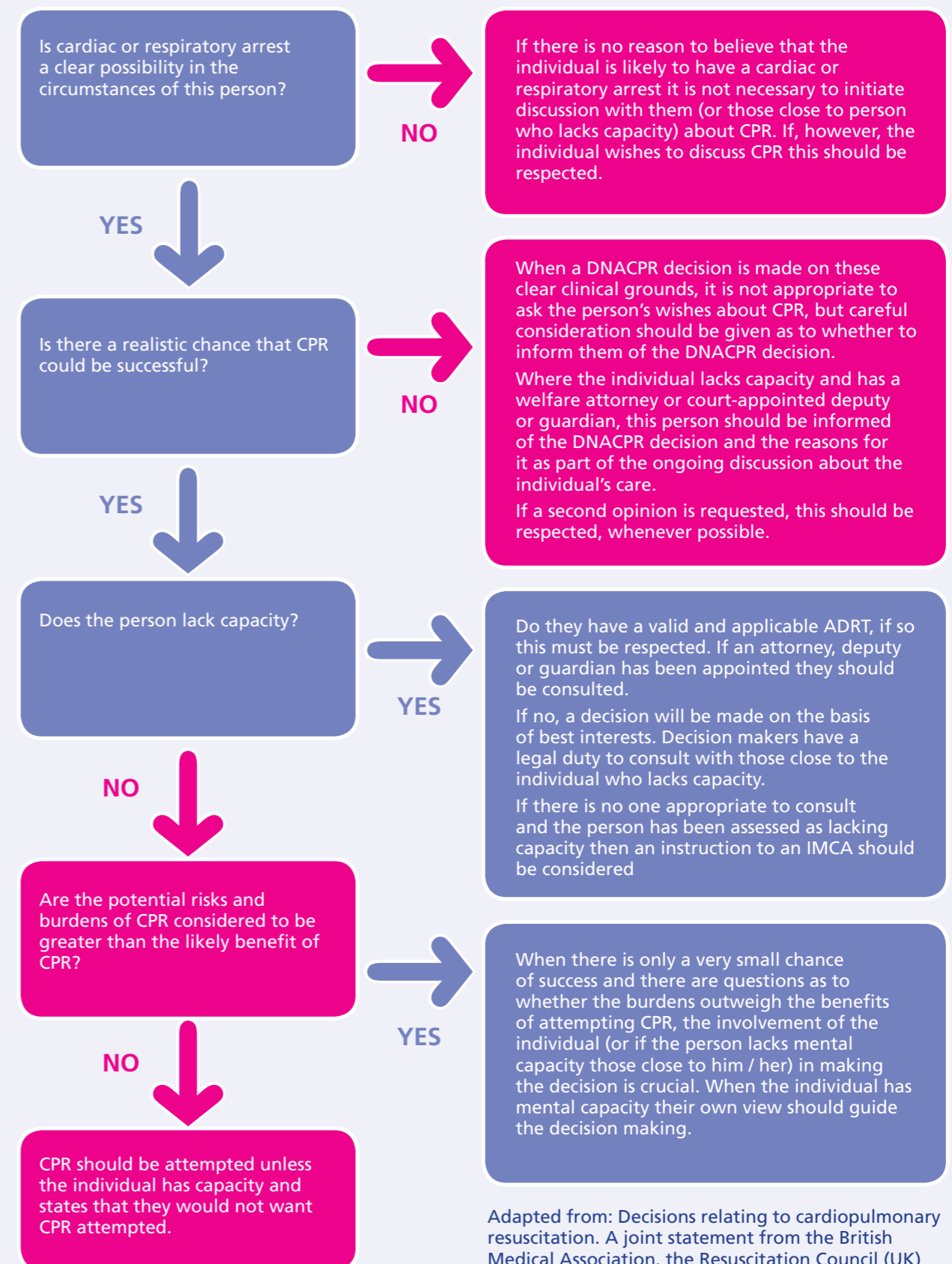
- where the individual's condition indicates that effective CPR is unlikely to be successful
- when CPR is likely to be followed by a length and quality of life not acceptable to the individual
- where CPR is not in accord with the recorded, sustained wishes of the individual who is deemed mentally competent or who has a valid applicable ADRT.

- 8.4. The decision-making framework is illustrated on page 10 - When considering making a DNACPR decision for an individual it is important to consider the following:
- is Cardiac Arrest (CA) a clear possibility for this individual? If not it may not be necessary to go any further
 - if CA 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 must be respected
 - if the individual has an irreversible condition where death is the likely outcome, the individual 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.
- 8.5 If a DNACPR discussion and decision is deemed appropriate the following needs to be considered:
- if a DNACPR decision is made and there has been no discussion with the individual because they have indicated a clear desire to avoid such discussion this must be documented and the reasons recorded
 - if a DNACPR decision is made following discussion with person / others, this must be documented in their notes
 - the DNACPR information leaflet should be made available, where 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.

See Decision-making framework opposite.

- 8.6.1 Documenting and communicating the decision - Once the decision has been made it must be recorded on the SCSHA approved Adult form (see appendix 1) and written in the person's notes. (Note:) **LILAC** form to stay with the person, white form, for audit purposes.
- 8.6.2 If using an electronic form ensure one copy is printed on lilac paper, signed and given to the person. A second copy needs to be stored for audit purposes.
- 8.7 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.
- 8.8 The form will stay with the person, it will located in the following places:
Hospitals, nursing homes, in-patient specialist palliative care setting: in the front of person's notes.
In the home: The tear off slip should be completed and placed in the "message in a bottle" in the person's refrigerator. The location of the DNACPR form needs to be clearly stated on the tear off strip. If a "message in a bottle" is not available, a system needs to be put in place to ensure effective communication of the DNACPR form's location to all relevant parties including South Central Ambulance Service.
www.lionsmd105.org/Community/MIAB/where_bottle.htm
GP surgeries: ensure that the DNACPR decision is recorded in the individual's electronic problem list using the appropriate Read Code.
- 8.9 **Ambulance transfer:** Ambulance crew must ensure that section 5 of the DNACPR form is completed prior to transfer.
Non ambulance transfer: between departments, other healthcare settings and home should be informed and abide by the DNACPR decision.
- 8.10 **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 their interests.
- 8.11 Acute Trusts need to verify DNACPR decisions made by a professional without overall responsibility for the person's care within 48 hours.

Decision-making framework



Adapted from: Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. October 2007.

9 Review

9.1 This decision will be regarded as **'Indefinite'** unless:

- a definite review date is specified.
- there are changes in the person's condition.
- their expressed wishes change.

The frequency of review should be determined by the health professional 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 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. Individuals should be encouraged to make an ADRT. Should the person refuse resuscitation, 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. A verbal request to decline resuscitation 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. Although individuals do not have a right to demand that doctors carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected wherever possible.

10.3 Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice may be indicated. This should very rarely be necessary.

11 Cancellation of a DNACPR Decision

In rare circumstances, a 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. 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 Suspension of DNACPR Decision

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 **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.

12.2 **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 Audit

13.1 The SCSHA will measure, monitor and evaluate compliance with this policy through audit and data collection using the Key Performance Indicators (KPI)

13.2 All organisations 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 and that can respond to the SCSHA request for audit purposes.

This includes:

- data collection
- ensuring that approved documentation is implemented
- managing risk
- sharing good practice
- monitoring of incident reports and complaints regarding the DNACPR process
- developing and ensuring that action plans are completed (see Appendix 3 audit tool).

13.3 Frequency and information.

- compliance with the policy will be audited annually using the SCSHA DNACPR Audit Tool (see Appendix 3)
- local leads will decide the number of DNACPR forms to be examined
- all institutions need to store the audit copy of the DNACPR form so that it is easily accessible when the local lead requests the information.

13.4 Information will be used for future planning, identification of training needs and for policy review.

14 References

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[Accessed 03-06-2009].

Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Policy Appendices

Appendix 1 Unified DNACPR Form This form will be in a book or printed on lilac paper WHO391

LILAC FORM TO PERSON - WHITE FORM FOR AUDIT

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

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

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

Date of DNACPR Decision
 ___ / ___ / _____



Form completed electronically? Yes No

Before completing this form, please see explanation notes.

1. Reason for DNACPR decision

A) CPR is unlikely to be successful due to _____
 This decision has been discussed with the person Yes No
 This decision has been discussed with relevant other Yes No
 Name of relevant other _____

B) CPR maybe successful, but followed by a length and quality of life which would not be of overall benefit to the person.
 • Person involved in discussions? Yes No
 • Person lacks mental capacity and has a legally appointed Welfare Attorney: Name _____
 • Person lacks mental capacity and does not have a legally appointed Welfare Attorney. Decision made on basis of benefit to the person in discussion with: Name(s) _____

C) DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.
 Valid and applicable Advance Decision to Refuse Treatment (ADRT) seen? Yes No
 Name _____ Position _____
 Signature _____ Date ___ / ___ / _____ Time ____ : ____

2. Healthcare professional making this DNACPR decision:

Name _____ Position _____
 Signature _____ Date ___ / ___ / _____ Time ____ : ____
 Healthcare professional verifying this DNACPR decision if original decision made by professional without overall responsibility for the person's care:
 Name _____ Position _____
 Signature _____ Date ___ / ___ / _____ Time ____ : ____

3. Review

Review date if appropriate ___ / ___ / _____ Outcome of review: DNACPR to continue? Yes No
 Name _____ Position _____
 Signature _____ Date ___ / ___ / _____ Time ____ : ____

4. Who has been informed of this DNACPR decision?

Person GP Ambulance Relative (Name) _____
 Acute Trust Nursing Home Hospice Community Hospital _____
 Out of Hours Other (Please state) _____

5. Ambulance crew instructions:

a) In the event of Cardio Pulmonary arrest, please do not attempt CPR or defibrillation for this person.
 b) All other types of supportive care should be given.
 c) If whilst in transit the person suddenly deteriorates continue journey and try to contact destination:
 Destination Name & telephone no. _____
 Next of Kin Name & telephone no. _____
 d) If whilst in transit the person dies take to nearest Mortuary / Emergency Department
 e) Name _____ Position _____
 Signature _____ Date ___ / ___ / _____ Time ____ : ____

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

The DNACPR form is located

Tear off slip and place in "message in a bottle"

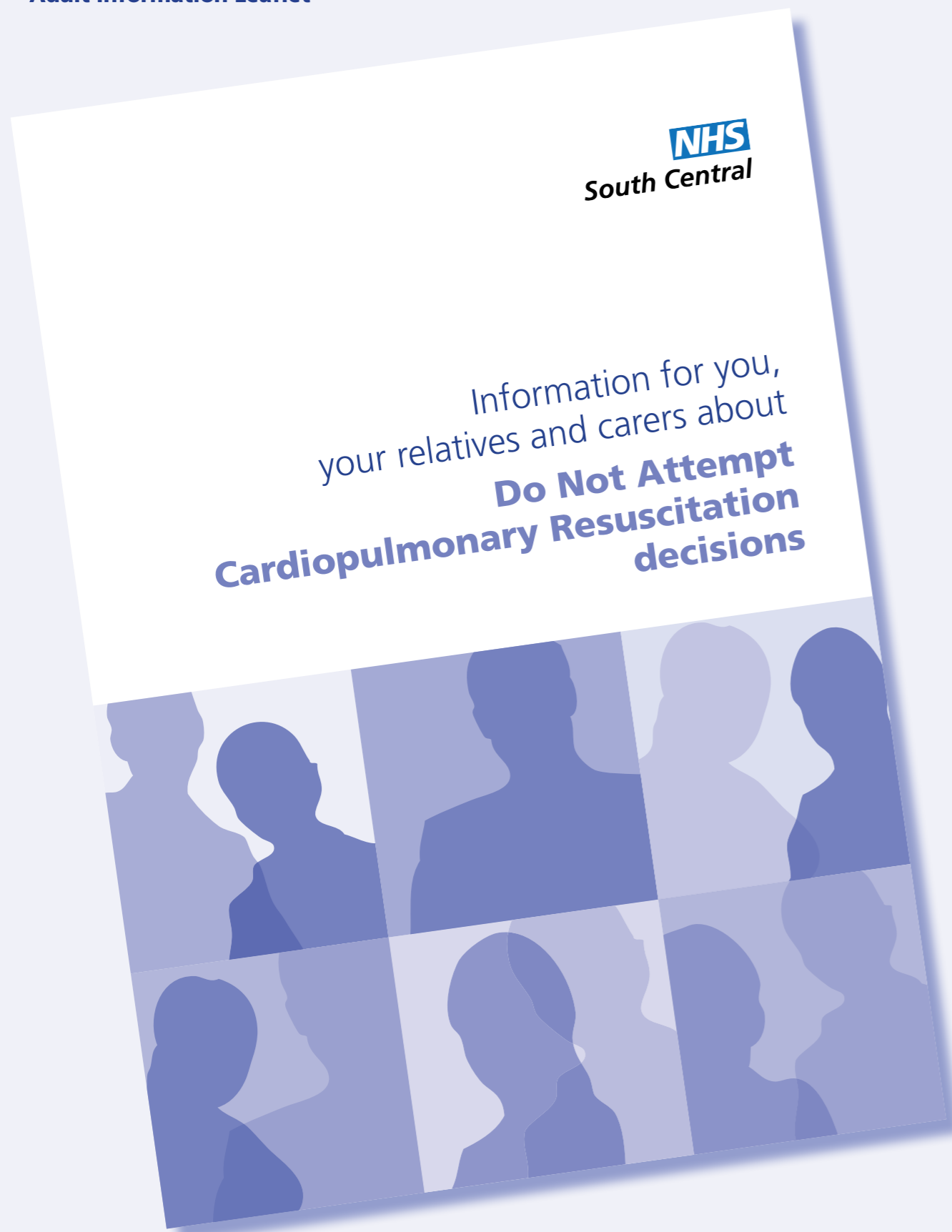
Notes This form should be completed legibly in black ball point ink

- The person's full name, NHS or Hospital number, date of birth and address should be written clearly.
- The date of writing the decision should be entered.
- 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.
- It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4.on form).
- Electronic form must be printed and signed on lilac paper and a copy kept for audit purposes.

1.	Reason for DNACPR decision	
1.A	CPR is unlikely to be successful	Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person's best interest's. Be as specific as possible. In this situation discussion with person / relevant other is not compulsory, unless the person is at home or being discharged home with the form. Record the details of discussion or the reason for not discussing in person's notes.
1.B	CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the person	Summary of communication with person... State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate. If the person does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the person would decide if able to do so. If there is no one appropriate to consult and the person has been assessed as lacking capacity then an instruction to an IMCA should be considered. If the person has made a Lasting Power of Attorney (LPA), 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 person if this power is included in the original Lasting Power of Attorney. You need to check this by reading the LPA. If the person has capacity ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives / relevant others with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
1.C	DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.	Record the assessment of capacity in the clinical notes. Ensure that any advance decision to refuse treatment is valid for the person's current circumstances. If this decision has not been discussed with the person or Welfare Attorney state the reason.
2.	Healthcare professional making this DNACPR decision/ Verification	State names and positions. In general this should be the most senior healthcare professional immediately available. The decision must be verified by the most senior healthcare professional responsible for the person's care at the earliest opportunity (within 48 hours in Acute Trusts). If the person making the decision is the most senior person, verification is not required.
3.	Review	A fixed review date is not recommended. This decision will be regarded as "INDEFINITE" unless: i) a definite review date is specified ii) there are changes in the person's condition iii) their expressed wishes change Reviewer needs to complete all details on the form and document the outcome in the notes.
4.	Who has been informed of this DNACPR decision?	Please ensure that all Health Care Professionals who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the person.
5.	Ambulance crew instructions	These should be completed by a doctor prior to ambulance transfer. Section c) is the name and telephone number of the destination and Next Of Kin (NOK). Section e) to be completed by the doctor.
	Tear off slip	Complete details and place in "message in a bottle" if available with location clearly stated.

Appendix 2

Adult Information Leaflet



Leaflet contents

This leaflet explains:**What cardiopulmonary resuscitation (CPR) is.****How you will know whether it is relevant to you.****How decisions about it are made.**

It is a general leaflet for everyone over 18 (if you are under 18 there is a separate leaflet) but it may also be useful to your relatives, friends, carers and others who are Important to you. This leaflet may not answer all your questions about CPR, but it should help you to think about the issue and the choices available. If you have any other questions, please talk to one of the health professionals (doctors, nurses and others) caring for you.

A DNACPR decision is about cardiopulmonary resuscitation only and you will receive all the other treatment that you need.

What is CPR?

Cardiopulmonary arrest means that a person's heart and breathing stop. When this happens it is sometimes possible to restart their heart and breathing with an emergency treatment called CPR.

CPR might include:

- repeatedly pushing down very firmly on the chest
- using electric shocks to try to restart the heart
- 'mouth-to-mouth' breathing; and
- Inflating the lungs through a mask over the nose and mouth or tube inserted into the windpipe.

Is CPR tried on everybody whose heart and breathing stop?

In an emergency, yes, if it is felt there is a chance it will work. For example, if a person has a serious injury or suffers a heart attack and the heart and breathing stop suddenly. The priority is to try to save the person's life.

However, if people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them. This is particularly true

when people have other things wrong with them.

Where a person has expressed his / her wishes not to have CPR this must be in writing. The information in this leaflet has been written to help you to decide whether or not you want to make this decision. It is important to remember that your relatives, friends or carers cannot make the decision for you.

Do people get back to normal after CPR?

Each person is different. A few people will make a full recovery; some recover but have health problems. Unfortunately, most attempts at CPR do not restart the heart and breathing despite the best efforts of all concerned. It depends on why their heart and breathing stopped and the person's general health. It also depends on how quickly their heart and breathing can be restarted.

People who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some people never get back the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some have brain damage or go into a coma. People with many medical problems are less likely to make a full recovery. The techniques used to start the heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs.

Am I likely to have a cardiopulmonary arrest?

This depends on your medical condition. The health professionals caring for you are the best people to discuss the likelihood of you having a cardiopulmonary arrest. People with the same symptoms do not necessarily have the same disease and people respond to illnesses differently. It is normal for health professionals and patients to plan what will happen in case of a cardiopulmonary arrest. Somebody from the health care team caring for you will talk to you about:

- your illness;
- what you can expect to happen; and
- what can be done to help you.

Leaflet contents continued

What is the chance of CPR reviving me if I have a cardiopulmonary arrest?

The chance of CPR reviving you will depend on:

- why your heart and breathing have stopped
- any illnesses or medical problems you have (or have had in the past)
- the overall condition of your health.

When CPR is attempted in hospital it is successful in restarting the heart and breathing in about 4 out of 10 patients. On average, 2 out of 10 patients survive long enough to leave hospital. The figures are much lower for people with serious underlying conditions or for those not in hospitals. Everybody is different and the healthcare team will explain what CPR may do for you.

Does it matter how old I am or that I have a disability?

No. What is important are, your current state of health; your current wishes; and the likelihood of the healthcare team being able to achieve what you want. Your age alone does not affect the decision, nor does the fact that you have a disability.

Will I be asked whether I want CPR?

If it is appropriate you and the healthcare professional in charge of your care will decide whether CPR should be attempted if your heart and breathing stop. The healthcare team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy. Sometimes, however, restarting a person's heart and breathing leaves them with a severe disability or prolongs suffering. Prolonging life in these circumstances is not always beneficial. Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in these discussions.

Legally, your family and friends are not allowed to decide or consent on your behalf, so you should inform your family and friends of your wishes. (For more information on The Mental Capacity Act please refer to: www.dca.gov.uk/legal-policy/mental-capacity/publications.htm). If you have appointed a person with Personal Welfare Attorney (PWA) then they may be able to consent on your behalf in certain situations if approached.

If it is decided that CPR won't be attempted, what then?

The healthcare team will continue to give you the best possible care. The healthcare professional in charge of your care will make sure that you, the healthcare team, and the friends and family that you want involved in the decision know and understand the decision. There will be a note in your health records that you are 'not for cardiopulmonary resuscitation'. This is called a 'do not attempt cardiopulmonary resuscitation' decision or DNACPR decision.

What if I don't want to decide?

You don't have to talk about CPR if you don't want to, or you can put discussion off if you feel you are being asked to decide too quickly. Your family, close friends, carers or those who you feel know you best might be able to help you make a decision you are comfortable with. Otherwise, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you have said.

What if a decision hasn't been made and I have a cardiopulmonary arrest?

The doctor in charge of your care will make a decision about what is right for you. Your family and friends are not allowed to decide for you, but it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be consulted you should let you care team know.

I know that I don't want anyone to try to resuscitate me. How can I make sure they don't?

If you don't want CPR, you can refuse it and the healthcare team must follow your wishes. You can make an Advanced Decision to Refuse Treatment (ADRT) (formerly known as a living will) to put your wishes in writing. This must be signed and witnessed. If the advance decision refuses life-sustaining treatment, it must:

- be in writing (it can be written by someone else or recorded in healthcare notes)
- be signed and witnessed, and
- state clearly that the decision applies even if 'life is at risk.'

If you have an ADRT, you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked.

For more information on Advance Decisions visit:

www.adrtnhs.co.uk
www.publicguardian.gov.uk

What if I want CPR to be attempted, but my doctor says it won't work?

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there was any real possibility of it being successful. If there is doubt whether CPR might work for you, the healthcare team will arrange a second medical opinion if you would like one. If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion where appropriate about whether these chances are worth taking is very important. The healthcare team will listen to your opinions and to the people close to you if you want them involved in the discussion.

What if I change my mind?

You can change your mind at any time, and talk to any of the healthcare team caring for you.

If you feel you have not had the chance to have a proper discussion with your care team, or you are not happy with the discussions you have had you can follow the formal complaints procedure. Please do not hesitate to keep asking questions until you understand all that you wish to know.

Who else can I talk to about this?

If you need to talk about this with someone outside of your family, friends or carers, to help you decide what you want, you may find it helpful to contact any of the following:

- Counsellors
- Independent Advocacy Services
- Patient Advice and Liaison Service (PALS)
- Patient Support services
- Spiritual carers, such as a chaplain.

Please insert local contact details in the box

Adapted from: Decisions about cardiopulmonary resuscitation model patient information leaflet, Resuscitation Council (UK), April 2008.

Appendix 3

Do not Attempt Cardio pulmonary Resuscitation (DNACPR) Policy Audit

Service: _____

Date: _____

	Question	Yes	No	Comments
1	Is there a DNACPR decision?			
2	Has the decision been recorded on approved documentation?			
3	Has the decision been made by an appropriate clinician?			
4	Is the record clearly dated, timed and signed in full?			
5	Are there clear patient identifiers?			
6	Are all fields of the records completed?			
7	Is there evidence that the mental capacity of the patient has been considered?			
8	Is there evidence of discussions with the patient?			
9	Is there evidence of discussions with the relatives, significant others or IMCA?			
10	Is there evidence that the multidisciplinary team are aware of the decision?			
11	Is there evidence that decisions are reviewed and documented?			
12	Is the DNACPR policy easily accessible to relevant staff?			
13	Has an electronic form been used?			

Appendix 4

Equality Impact Assessment (EIA) - Evidence Form - Example

South Central Strategic Health Authority strives to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. This form is designed to help you to consider the needs and assess the positive, adverse or neutral impact of your policy, protocol, proposal or service on all groups within our local communities, and to record the evidence that you have done so. Any proposal or policy submitted to the Board must have undergone EIA.

This form will be used as evidence of the assessment you have undertaken. It will need to be made available to the Board and Equality and Diversity Steering Group.

Policy/Proposal/Service Title:

Do Not Attempt Cardiopulmonary Resuscitation Adult Policy

Name of EIA Lead: Chris Penhale

Others involved in assessment: Tracey Courtnell

Date EIA commenced: 6th August 2009

EIA Completed and Approved

Signature (Lead Director): _____

Name (print): _____

Job Title: _____

Date: _____

ONCE COMPLETED, PLEASE SUBMIT TO EQUALITY AND DIVERSITY LEAD FOR EVIDENCE AND PUBLICATION.