Nottinghamshire Hospice
adding life to days

Policy/Procedure Information (Policy No CS002)	
Subject	**Resuscitation/DNACPR Policy** *(This policy is subject to periodic review and will be amended according to service development needs)*
Applicable to	This policy applies to all staff, voluntary workers, students, and agency workers, at all sites, where patient care is being provided on behalf of Nottinghamshire Hospice.
Date issued	2022
Next review date	2025
Lead responsible for Policy	Director of Care Services
Policy Reviewed by	Governance Lead
Notified to (when)	Quality and Safety Group (September 2022)
Authorised by (when)	Quality and Safety Group September 2022
CQC Standard	SAFE, CARING, RESPONSIVE
Links to other Hospice Policies	Mental Capacity Policy CS007 Adult Safeguarding Policy HM009
Links to external policies	
Summary	This policy applies to DNACPR decisions for patients who are 18 years and over. This policy is intended to prevent inappropriate, futile and/or unwanted attempts at cardiopulmonary resuscitation for adult patients being cared for by Nottinghamshire Hospice. It does not refer to other aspects of care, for example, analgesia, antibiotics, suction, and treatment of choking, treatment of anaphylaxis or other interventions which are sometimes loosely referred to as “resuscitation”.
This Policy replaces	

VERSION CONTROL		
Status	**Approval date**	**Review due**
Original policy written by Betsie Van Niekerk, Hospice Physician	April 2014	April 2016
Policy reviewed and updated by Donna Payne, Director of Operations	April 2017	Feb 2019
Policy reviewed by Hospice Care Team	Feb 2019	
Policy notified to Quality & Safety group	March 2019	
Policy authorised by Board of Trustees	March 2019	March 2021
Updated control sheet and published on Policy Doc App	March 2019	
Logo updated and published on website	Dec 2020	
Policy reviewed by Governance Lead	August 2022	

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1. INTRODUCTION

Cardiopulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically CPR could be used on every individual prior to death. It is, therefore, essential to identify patients who are nearing end of life for whom CPR is inappropriate. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to ensure that if death occurs there is no added loss of dignity. It is also essential to identify those patients who would not want CPR to be attempted in the event of a cardiorespiratory arrest and who competently refuse this treatment option.

All DNACPR decisions are clinical must be based on current legislation and guidance. For situations 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. POLICY STATEMENT

Nottinghamshire Hospice is required to have a resuscitation policy in place that reflects recommended practice in the following areas:

- The Human Rights Act (1998) is relevant to this policy in the following sections
    - 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
- Mental Capacity Act 2005
- Decisions relating to cardiopulmonary resuscitation: A joint guidance from the BMA, Resuscitation Council (UK) and the Royal College of Nursing (RCN on decisions about CPR – including decisions not to attempt CPR. (1. BMA)
- Resuscitation UK. – DNACPR Guidance (2. Resuscitations UK)
- General Medical Council (2019) Treatment on Care towards the end of life: good practice in decision making. (3. GMC)

- Local NHS policies in Nottingham City and County

All patients are presumed to be 'for Cardio-Pulmonary Resuscitation (CPR)': unless a valid DNACPR decision has been made and documented on the standardised Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form for adults (see appendix 1) or An Advanced Decision to Refuse Treatment (ADRT) prohibits CPR exists.

Variations in local policies can cause misunderstandings and lead to distressing incidents for patients, families and staff. Increased movement of patients and staff between different care settings means that a patient care may be influenced by more than one policy. This policy attempts to ensure that it embeds recommended practice and reflect other policies in organisations we work in partnership with to care for dying people.

3. PURPOSE

This policy will provide clear guidance for clinical staff and a framework to ensure that any DNACPR decisions they are involved in:

- Refer only to CPR and not to any other aspect of the individual's care or treatment options
- Respect the wishes of the individual, where possible
- Reflect the best interests of the individual
- Provide benefits that are not outweighed by burden

For staff to know their responsibilities when patients have recorded or stated their wishes in relation to resuscitation.

For staff to know what the procedure is when there is no DNACPR in place and a patient has a cardiac arrest.

For staff to be encouraged to enter into an appropriate conversation with any patient receiving services who wishes to discuss their DNACPR and for appropriately trained staff to complete DNACPR forms with patients if this is the patient's choice.

This policy details the standards and considerations relating to cardiopulmonary resuscitation decisions for patients.

4. DEFINITIONS

Advanced 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

Cardiopulmonary 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.

Court Appointed Deputy

Is 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.

Do Not Attempt Cardiopulmonary 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.

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

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.

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.

Mental Capacity

An individual over the age of 16 is always 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 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

Mental Capacity Act (2005) (MCA)

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. Under the Mental Capacity Act (2005), clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

5. ROLES AND RESPONSIBILITIES

Chief Executive

Has ultimate accountability for ensuring robust systems are in place across the organisation.

Director of Care

- To determine, implement and review this policy and Nottinghamshire Hospice capabilities to ensure this this policy is in line with local and national guidelines
- To provide effective CPR processes and to ensure that basic life support and DNACPR training is available for staff to ensure they are sufficiently skilled to undertake CPR and completion of DNACPR forms should it be required

Deputy Director of Care

- To ensure that procedures regarding the management of resuscitation and DNACPR form completion are adhered to.
- To ensure that clinical staff (including bank) have attended basic life support training and their training is up to date

- To ensure that conversations regarding resuscitation with patients and carers are clearly documented and shared appropriately.

Clinical Staff

- To have read and understood this policy and fully cooperate with its implementation
- To complete all required documentation in a timely manner
- To ensure that any active DNACPR form is reflected in patients' records
- Attend and participate in training as required
- Raise any queries with their line manager

6. PRINCIPLES FOR PRACTICES

For many people anticipatory decisions about CPR are best made in the wider context of their advance care planning before a crisis necessitates a hurried decision. Making decisions about whether CPR should be attempted is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

Every decision about CPR must be made based on a careful assessment of an individual's situation. These decisions should never be dictated by 'blanket' policies.

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.

The hospice supports the stance that when a decision about future CPR is being 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.

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, the hospice is in favour of the presumption 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.

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.

There should always be clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including, provision of information and checking their understanding of what has been explained to them.

Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.

Where a patient or those close to a patient disagree with a DNACPR decision there should be an attempt to provide a second opinion.

A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include, but are not restricted to, choking, a displaced tracheal tube or a blocked tracheostomy tube.

A CPR decision form is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding

whether to attempt CPR rests with the healthcare professionals responsible for the patient's immediate care.

Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

7. PROCESS

In the event of an unexpected cardiac arrest every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council (UK) unless a valid DNACPR decision or an ADRT is in place and made known.

In the event of finding a person with no signs of life and where there is no DNACPR decision or an ADRT to refuse CPR, the clinical / healthcare professional must rapidly assess the case as to whether it is appropriate to commence CPR. Providing the clinician/ healthcare professional has demonstrated a rational process in decision making, the hospice will support the member of staff if this decision is challenged. Professional judgement must be exercised and documented as soon as practically possible after the event. Consideration of the following will help to form a decision:

- What is the likely expected outcome of undertaking CPR? For example, it would be inappropriate to start CPR if it will not re-start the heart and maintain breathing.
- What is the balance between the right to life and the right to be free from inhuman and degrading treatment (Human Rights Act 1998)?

It is rarely appropriate to discuss DNACPR decisions in isolation from other aspects of end-of-life care. DNACPR is only one small aspect of advance care planning which can help patients achieve their wishes for their end-of-life care. The patient should be given as much information as they wish about their situation, including information about CPR in the context of their own illness and sensitive communication around dying and end of life issues.

All people are assumed to have capacity unless otherwise stated or they are incapacitated at the time of the decision e.g., unconscious. In emergency situations urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies.

Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form.

Following transfer between healthcare settings, DNACPR decisions remain valid but should be verified as soon as possible by the clinician/ healthcare professional with overall responsibility for the person's care. Unless there is a good reason to believe the DNACPR decision is not genuine or applicable, it should be accepted as valid until the decision is reviewed by the patient's responsible senior clinician. Similarly, a photocopy of a DNACPR form should be accepted unless there is evidence it should not be considered valid.

A copy of the original DNACPR form must accompany a patient when they move from one setting to another. This must be dated and signed by the person copying it to ensure that it is clear when the copy was taken and where the original form sits.

The existence of a DNACPR should be recorded in EPaCCs.

Nottinghamshire Hospice ensures that all care staff receive training in the ReSPECT process (Appendix 3).

8. CANCELLATION OF DNACPR DECISION

If the person's clinical condition changes, the decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form must be crossed through with two diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the clinician /healthcare professional, who will print their name and professional registration number clearly underneath their signature for purposes of validation. Without this validation the order will not be considered revoked.

It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all relevant parties involved in the care of the patient

9. PATIENTS WITH AN IMPLANTABLE CARDIOVERTER DEFRIBRILLATOR (ICD)

It is the responsibility of the clinician in charge of the patients' care to address the potential need to deactivate the defibrillator function of an ICD.

The pacemaker function should remain active, even in terminally ill patients, as deactivation may potentially accelerate the dying process.

Patients deemed to be approaching end stage heart failure, or other illness, are at risk of developing complex arrhythmias which may trigger the firing of the ICD. In these circumstances, it would be inappropriate to maintain the ICD in active mode, resulting in patient distress.

In accordance with good practice, it is the patient's senior doctor who should consult with patient and their carers where appropriate, to incorporate the ICD deactivation decision process in the patients' plan of care. This should be done prior to the very end stage of life to avoid unnecessary patient mental and physical distress.

For those patients who lack capacity, clinicians must adhere to the guidelines outlined in the 2005 Mental Capacity Act during the decision-making process.

The British Heart Foundation discussion document for Health Professionals entitled; "Implantable Cardioverter Defibrillators in Patients that are reaching the end stage of life" can be used as source of information.

11. DEFIBRILLATOR

The hospice day therapy will contain a portable 'Lay Rescuer' automated defibrillator for use by staff who have received training. When in use staff will follow the instructions provided by the automated unit.

12. EDUCATION AND TRAINING

This policy and associated documents will be covered in the programme for the Basic Life Support training sessions provided at staff induction and annual mandatory training events.

All staff (and volunteers working with patients in the community) who are involved in the delivery of patient care will attend mandatory resuscitation and defibrillator training.

Further training requirements should be identified with managers through the appraisal process and in conjunction with the training needs analysis.

Where staff are not found capable of preforming CPR this will be discussed between the individual and their line manager and if necessary managed through the Capability Policy and Procedure.

Staff completing DNACPR forms should be deemed competent to do so by having attended specific training.

13. AUDIT AND REVIEW

Compliance with this policy will be monitored through training records attendance, and any reported adverse incidents related to the resuscitation of patients.

The Quality and Safety Committee will review this policy and ensure that it is scheduled for review periodically and any lessons learnt and best practice identified regarding resuscitation will be shared across the organisation and included in this policy.

14. REFERENCES

1. "Decisions relating to Cardiopulmonary Resuscitation" *(3rd Edition 1st Revision)* Resuscitation Council (UK) 2016 Publication: Decisions relating to cardiopulmonary resuscitation (3rd edition - 1st revision) | Resuscitation Council UK
2. Resuscitation Council UK
3. Treatment on Care towards the end of life: good practice in decision making. General Medical Council (2019)

Appendix 1: UNIFIED DNACPR FORM (Nottingham)

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) NHS

This document applies to CPR decisions exclusively and must be used in accordance with local resuscitation policy
The person must be appropriately assessed to ensure they receive all other appropriate care.
Form developed by the NHS in the East Midlands.

Section 1: DNACPR Category. Delete A or B to identify which applies

A. For a person at the end of life. DNACPR applies across all care settings. No review necessary.

OR

B. DNACPR decision for periodic review during admission/change in place of care or on discharge. State the first review date in section 5. (Should option A then become applicable a new form must be completed)

ORIGINATED BY (Optional):
e.g. Doctor in training (PRINT) ..... Signature .....
GMC No ..... Date .....

ORIGINATED BY AND/OR ENDORSED BY (Obligatory):
Responsible clinician/nurse (PRINT) ..... Signature .....
Designation ..... Date ..... Organisation .....
If applicable GMC No .....

Addressograph Label

Patient name:

Address:

Date of birth:

NHS No:

Telephone No:

Location of patient when DNACPR form completed

Section 2: Reason for DNACPR (please tick those that apply):

Patient's condition indicates that CPR is unlikely to be successful because ..... ☐
.....

CPR is not in accord with a valid Advance Decision to Refuse Treatment ☐

Patient does not consent to CPR ☐

Section 3: Communication with patient and carer/relevant others (Tick all that apply):

It is good practice to explain why CPR will not be attempted, *unless doing so would cause unnecessary distress.*

This **has** been discussed with the patient ☐
This **has** been discussed with ..... *(name)* on ☐
date..... Relationship to patient .....
contact details .....
This **has not** been discussed with the patient because it would cause unnecessary distress or they lack capacity (delete as applicable) ☐
This **has not** been discussed with any relevant other e.g. family/carer ☐
because .....

Fully record details of all CPR discussions in the patient's notes

Section 4: Complete section below only for patients who lack capacity

Does the patient have a legally appointed and registered welfare attorney?	**Yes**	**No**
Have they been consulted and discussion documented? (if yes to question above)	**Yes**	**No**
If no attorney or others to contribute to Best Interests decision, has an IMCA been contacted?	**Yes**	**No**
Confirm that decision made following the best interest process of Mental Capacity Act	**Yes**	**No**

Fully record details in the patient's notes

Section 5: DNACPR review. Please complete if indicated by B in section 1 on the date stated below

Date of review	Reviewer's name (capitals)	Reviewer's signature	Next review due	Designation & contact details	Location of patient

Section 6: IF DNACPR CANCELLED – CLEARLY CROSS THROUGH DOCUMENT WITH 2 LINES NAME, DATE AND SIGN with a reason for cancellation

Section 7: Organisational communication

The clinical team must ensure the DNACPR paperwork accompanies the patient on transfers and that professional colleagues receiving the patient are aware of the decision

Patient's GP..... Telephone No .....
Address .....

Professional contact out of hours Name.....
Telephone No..... Address .....

Has person in charge of patient's daily care (e.g. GP, Community Nurse or Care Home) been informed Yes No

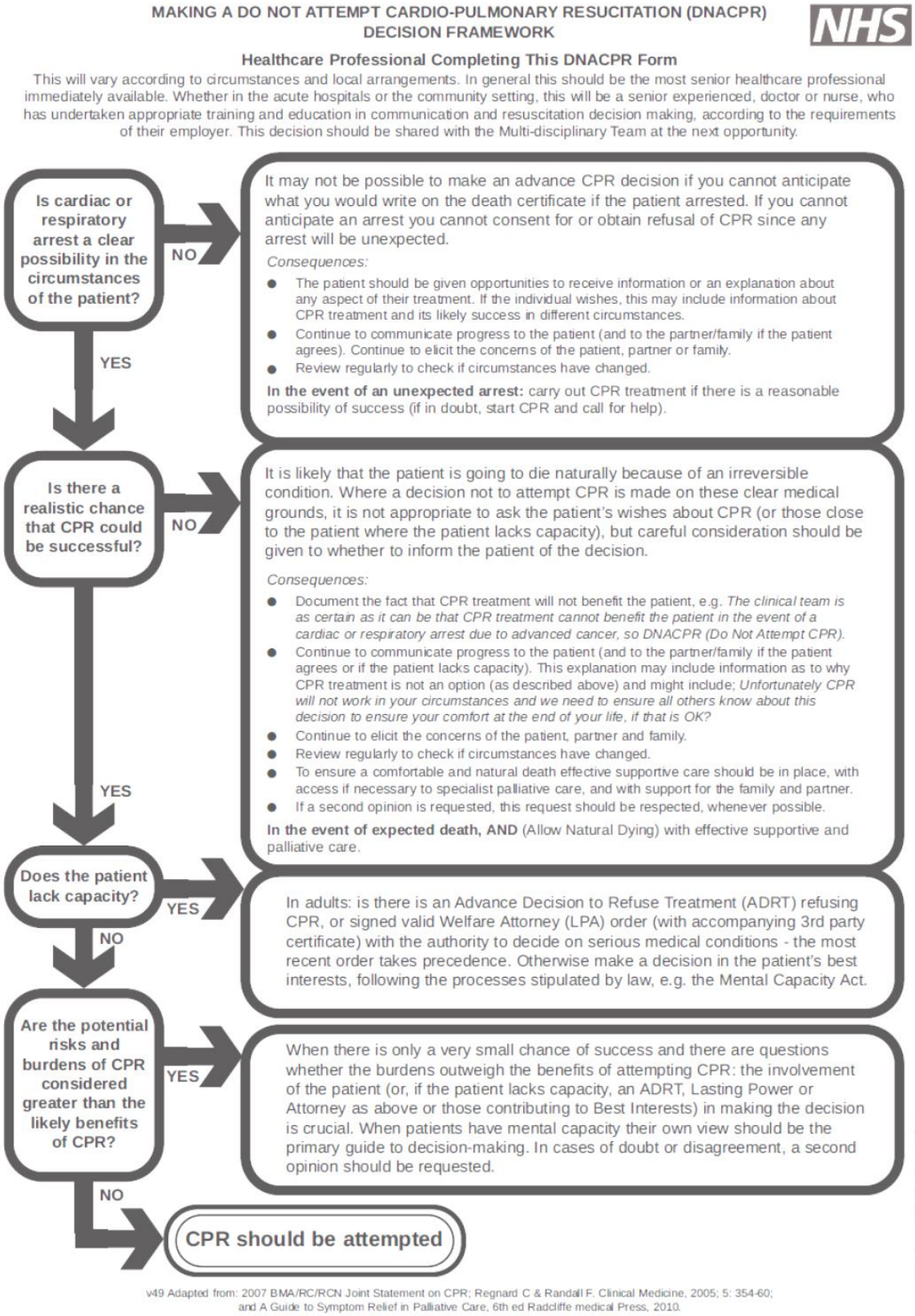
A copy should be kept in the notes exclusively for audit purposes and marked as COPY.

When at home or place of care/residence ensure the original form is accessible to visiting health or social care professionals. E.g. place the form at front of community notes or message in a bottle. Ensure it is ready should an emergency/urgent call be made

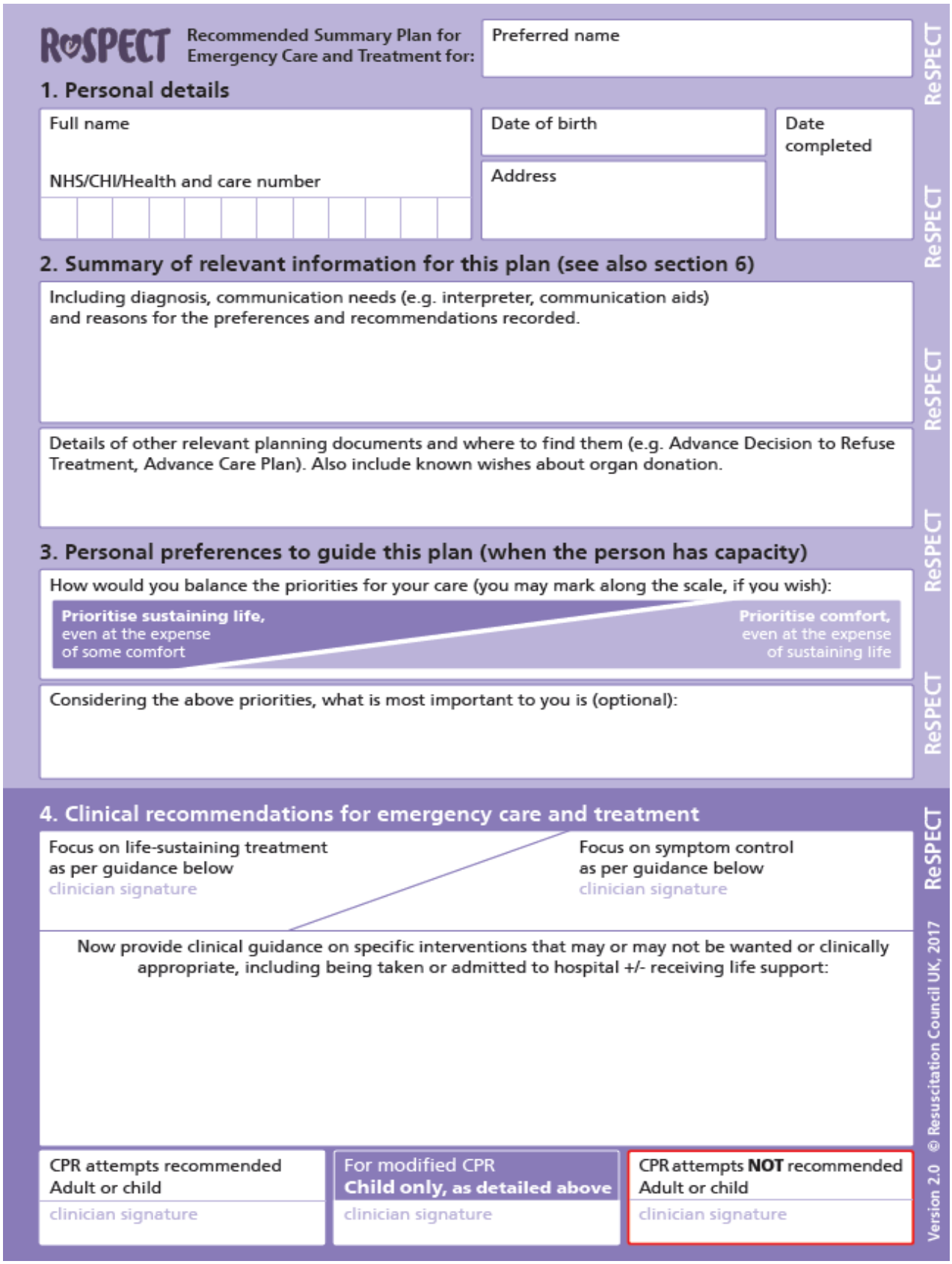
Does the patient have a preferred place of care at the end of life? Yes No

If yes, where? Tick Box - Home ☐ Hospital ☐ Care Home ☐ Hospice ☐ Other (please state) .....

Appendix 2: Making a Do Not Attempt Cardiopulmonary Resuscitation decision making framework



Appendix 3: Respect Form



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child
clinician signature

For modified CPR **Child only, as detailed above**
clinician signature

CPR attempts **NOT** recommended Adult or child
clinician signature

ReSPECT

Version 2.0 © Resuscitation Council UK, 2017

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.

☐ **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time

Senior responsible clinician

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend/other			
GP			
Lead Consultant			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature