Blackpool Teaching Hospitals NHS
NHS Foundation Trust

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Title: **Do Not Attempt Cardiopulmonary Resuscitation (Adults, including Community Services)**		**Version Number:** 8
		Status: Ratified
Scope: Trust Wide		**Classification:** Organisational
Author/Originator and title: Dr Jason Cupitt, Consultant Anaesthetist		**Responsibility:** Resuscitation Department
Replaces: Version 7 Do Not Attempt Resuscitation (Adults) Corp/Proc/003 Management of Resuscitation NHSB/Clin041 NHS North Lancashire Resuscitation Policy 109/06	**Description of amendments:** Inclusion of Community Services Amendments throughout	
Name Of: Divisional/Directorate/Working Group: Care of the Acutely Ill Patients Group Chairman's Action	**Date of Meeting:** 06/08/2012	**Risk Assessment:** N/A **Financial Implications** N/A
Validated by: Dr Jason Cupitt, Consultant Anaesthetist	**Validation Date:** 06/08/2012	**Which Principles of the NHS Constitution Apply?** Principle 1-4
Ratified by: Clinical Improvement Committee	**Ratified Date:** 07/08/2012	**Issue Date:** 07/08/2012
Review dates may alter if any significant changes are made		**Review Date:** 01/07/2015
Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Initial Assessment		

1. PURPOSE

This document details the procedure to be used in the event of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order being made on an adult patient suffering a cardiac and / or respiratory arrest and must be read in conjunction with:

- Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT) Resuscitation Policy (CORP/POL/003, see section 7) and Cardiopulmonary Resuscitation (CPR) Procedure (CORP/PROC/083, see section 7).

- Trinity Hospice and Palliative Care Services Resuscitation Policy for the Adult In-Patient and Day Unit (15C).

2. SCOPE

This procedure applies to all staff employed by Blackpool Teaching Hospitals NHS Foundation Trust and Trinity Hospice and Palliative Care Services.

2.1 Duties

2.1.2 Service Managers

Service Managers are accountable for ensuring that their staff are sufficiently trained and are competent to apply this guidance appropriately.

2.1.3 Line Managers

It is the responsibility of Line Managers to ensure their staff are aware of this guidance and comply with their responsibilities. They are responsible for ensuring that their staff have attended all relevant training.

3. PROCEDURE

Healthcare organisations have an obligation to provide an effective resuscitation service to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities.

It is the responsibility of the NHS Blackpool and NHS North Lancashire Joint Clinical Standards Group, Clinical Improvement Committee, the Blackpool Teaching Hospitals NHS Foundation Trust Care of the Acutely Ill Patient Group and Resuscitation Committee, and Trinity Hospice and Palliative Care Services Clinical Leadership Group to ensure procedure distribution, implementation and compliance.

3.1 Duties Of Staff In Identifying The Need For A Decision As To Whether CPR Should Be Provided

Cardiopulmonary resuscitation (CPR) is a potentially life-saving procedure when delivered by appropriately trained personnel. However, it must be taken into consideration that, in some circumstances, such an intervention may be perceived as inappropriate, futile or unlawful. Injudicious use of CPR may cause unnecessary trauma, leading to an undignified death, or to the prolongation of pain and suffering of patients. It is therefore important to identify those patients in whom CPR would be inappropriate and where attempts to prolong life are merely actions that would prolong the process of dying.

Where a situation arises in which it is necessary to consider whether or not CPR should be undertaken, it is the responsibility of staff involved in the patient's care to raise the issue with the Consultant or General Practitioner (GP) responsible for the patient's management so that a decision can be taken as to whether or not CPR is going to be appropriate in the event of the patient suffering a cardiac or respiratory arrest.

A letter from the Chief Medical Officer (PL/CMO(91)22) makes it clear that the responsibility for making a DNACPR order is that of the Consultant or GP in charge of the patient's care. As with other forms of patient management, this responsibility may have to be delegated to the next most senior doctor on duty who is competent to carry it out. This situation may arise out-of-hours and before the Consultant or GP has reviewed the patient. However, like any other decision taken by a trainee doctor or deputising out-of-hours GP, the ultimate responsibility remains with the patient's Consultant or own GP and should be confirmed by him or her at the earliest opportunity: both verbally and by obtaining the Consultant or own GP's signature on the DNACPR form endorsing the DNACPR decision. Wherever possible, a decision should be agreed with the whole healthcare team.

Arrangements must be made within the appropriate hospital Division / Directorate to ensure that mechanisms exist for Junior Medical Staff to have ready access to senior doctor involvement. Within Blackpool Teaching Hospital NHS Foundation Trust, each Consultant must also ensure that all Junior Doctors working for him, or her, are instructed in the working of the Resuscitation Policy (CORP/POL/003, see section 7). Within Trinity Hospice, the same must be done for the Trinity Hospice and Palliative Care Services Resuscitation Policy for the Adult In-Patient and Day Unit (15C).

Delegating responsibility does not alter the process. The entire procedure must be followed, including patient and relative involvement where appropriate, and fully documented in the case notes/patient records. In situations where responsibility has been delegated in this manner, advice and support will always be available from the Consultant on call or patient's own GP if in a community setting.

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as patient's age, disability, or on a professional's subjective view of a patient's quality of life. The key issue to consider is not the decision-makers view of the patient's disability or level of recovery that can reasonably be expected following CPR but an objective assessment of what is in the best interests of the patient, taking account of all relevant factors, particularly the patient's own views. The benefits of prolonging life must be weighed against the potential burdens to the patient. The duty to protect life must be balanced with the obligation not to subject the patient to inhuman or degrading and futile treatment, from which the patient will derive no overall benefit, while considering also any expressed wishes of the patient.

There may be situations in which CPR is commenced following cardiorespiratory arrest, but during resuscitation further information comes to light that makes further CPR inappropriate. That information may consist of a DNACPR order or a valid and applicable advance decision refusing CPR, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued resuscitation would be inappropriate. There will be some patients for whom attempting CPR is clearly

inappropriate; for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal decision has been made. In such circumstances, healthcare workers who make a considered decision not to commence CPR should be supported by their senior colleagues.

A DNACPR order is not the same as a decision to stop CPR that has proven unsuccessful. Stopping CPR is an entirely clinical decision and must be made by the most senior doctor in attendance, with the agreement of the team assembled.

3.2 Circumstances Where It May Be Considered Inappropriate To Carry Out CPR

i. When the patient's condition indicates that CPR would not be successful.

ii. Where CPR is not in accordance with the wishes of a patient who is mentally competent.

iii. Where CPR is not in accordance with a valid and applicable advance decision to refuse treatment (Blackpool Teaching Hospitals NHS Foundation Trust Advanced Decisions / Living Will Policy, CORP/POL/109, see section 7, and Trinity Hospice and Palliative Care Services 15C).

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

v. Where CPR is not in accordance with the wishes of a person properly authorised to make decisions regarding life-sustaining treatment on behalf of the patient under the Mental Capacity Act 2005 Lasting Power of Attorney for Health and Welfare provisions.

vi. When the patient has been commenced on the Liverpool Care Pathway (LCP) for the Dying Patient, CORP/GUID/145 (see section 7).

Further advice should be sought where CPR is not considered appropriate solely because it would not be in accordance with a valid and applicable advance decision to refuse treatment or where someone has been appointed to act as a personal welfare attorney under a Lasting Power of Attorney (as per (iii) and (v) above). The provisions for making advance decisions to refuse treatment require certain formalities to be fulfilled before a patient can make a binding advance decision to refuse life-saving treatment that would otherwise be in their best interests, or authorise anyone to refuse such treatment on their behalf.

3.3 Involvement Of Patients And Their Relatives In The Decision Making Process (Refer To Appendix 1: Decision-Making Framework)

Information regarding decisions around CPR must be readily available to both patients and also their relatives and carers. Staff must provide patients with such information as a routine part of advance care planning to cover all contingencies.

Staff should work on the presumption that every adult patient has the capacity to make decisions about whether or not CPR should be administered unless it is clear that, after the patient has been given all appropriate help and support, they cannot understand,

retain, use or weigh up the information needed to make the decision or communicate their wishes.

If a patient prompts a discussion about CPR/DNACPR, refer to the patient information leaflet “Decisions About Adult CPR”. The patient’s views must then be explored. If a patient who has capacity has expressed a wish not to discuss CPR, it is neither necessary nor appropriate to initiate discussion with the patient to explore their wishes regarding CPR.

If CPR may be successful, the benefits of prolonging life must be weighed against the potential burdens to the patient. This is not solely a clinical decision and must involve consideration of the patient’s broader best interests including their wishes. In these circumstances, discussion with the patient (or, if the patient lacks capacity, those close to the patient) about whether CPR should be attempted is an essential part of the decision-making process. Patients should be informed in a sensitive manner of the facts and of the possible risks and adverse effects in order to make informed decisions about whether or not they would want CPR. The approach taken will depend on whether or not the patient has capacity to make treatment decisions, as follows:

3.3.1. Patients With Capacity

Where a patient with capacity has been identified as the potential subject of a DNACPR order, careful consideration should be given as to whether or not to inform the patient of the decision. Although patients should be helped to understand the severity of their condition and the likely outcome of any future treatment, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases a patient should be informed and there must be a good, reasonable and defensible excuse for not having the appropriate discussions. However for some patients, for example those who know that they are approaching the end of their life, information about interventions that would not be clinically successful will be unnecessarily burdensome and of little or no value.

If however a patient with capacity asks directly whether CPR is to be administered the questions should be answered. Other patients may indicate by their actions and involvement in decision-making that they want detailed information about their care and want to be fully involved in planning for the end of their life. The decision must be one that is right for the patient and information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team.

The discussion must be prompted and led by the Consultant or GP in charge of the patient’s care and treatment, or by the next most senior doctor available. If a particular member of the team has established a rapport with the patient, s/he should be present during any such discussion. A patient with capacity may consent to the question of resuscitation being discussed with his/her family, friends and/or carers, but in the absence of consent, no such discussion should take place. The question of resuscitation, and in particular, the possibility that it might be withheld, raises sensitive and potentially distressing issues for patients, and for their relatives, friends and/or carers.

3.3.2. Patients Who Lack Capacity

A patient who lacks capacity is entitled to the same confidentiality as a patient who has capacity. However, those responsible for providing care and treatment to a patient who

lacks capacity must do so in his/her 'best interests', and they must ensure that they obtain sufficient information to enable them to do so. Information should be obtained from the relatives, friends and carers of a patient who lacks capacity, and it might include such things as any wishes or thoughts expressed by the patient him/herself, especially if they were expressed when the patient had capacity, such as a verbal or written advance statement of wishes. The relatives, friends and/or carers of a patient who lacks capacity must not be given - nor must they be led to believe that they will have - responsibility for deciding what care and treatment must be given to him/her. Likewise, nothing they say will be binding on those that must make that decision. It is for the clinical team, and in particular, for the Consultant or GP in charge of their care and treatment, to make that decision in the case of a patient who lacks capacity.

When the patient lacks the capacity to make or communicate a decision, it is important to establish whether the patient has made a valid advance decision that they should not receive CPR. In addition some patients may have appointed a person to act as a personal welfare attorney by way of a Lasting Power of Attorney for Health and Welfare to make decisions about their personal welfare, which can include the power to refuse life-sustaining medical treatment. If staff are aware that a person has been appointed to make personal welfare decisions, that person must be consulted where practicable. They must be informed of DNACPR decisions and the reasons for it. Further advice should be sought, as the extent of the power to refuse life-sustaining treatment depends upon the precise terms of the Lasting Power of Attorney: Guidance on the Mental Capacity Act 2005 and refer to Section 7 of Implementing the Mental Capacity Act 2005 and Apply the Supporting Code of Practice Policy Corp/Pol/196 and Guideline Corp/Guid/083 (see section 7).

3.4. Practical Consequences Of Clinical Decision Not To Provide CPR

A decision not to provide CPR does not mean that the patient is to receive no further treatment. The instruction simply means that full CPR is agreed to be inappropriate for the patient and hence for patients in hospital the cardiac arrest team should not be called automatically in the event of a cardiac or respiratory arrest. For patients in the community or hospice setting an emergency ambulance should not be called.

Some patients for whom a DNACPR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, anaphylaxis or blocked tracheostomy tube. In such situations CPR may be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. In addition to readily reversibly causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiorespiratory arrest – for example, cardiac catheterisation, pacemaker insertion, or surgical operations. DNACPR decisions should be reviewed in advance of the procedure and ideally this should be discussed with the patient, or their representative, as part of the consent process. If a patient wishes an advance decision refusing CPR to remain valid during a procedure or treatment that increases the risk of or induces cardiorespiratory arrest, this may significantly increase the risks of the procedure or treatment itself. If a clinician believes that the procedure or treatment would not be successful with the DNACPR order still in place, it would be reasonable not to proceed. Neither patients, nor those close to them, can demand treatment that is clinically inappropriate.

If the healthcare team believes that CPR will not re-start the heart and/or breathing, or the outcome of CPR will not be of overall benefit to the patient, this should be explained in a sensitive way. If the patient, or those close to the patient, does not accept the decision, a second opinion should be offered. If it is not possible to reach a consensus about whether to provide CPR and there remains significant disagreement between the family, carers and the healthcare professionals, staff should consider taking legal advice on whether to apply to the court for a ruling.

3.5. Procedure For Making A Do Not Attempt Cardiopulmonary Resuscitation Order

The ultimate responsibility for making a DNACPR order lies with the Consultant/GP in charge of the patient's care. When a DNACPR decision is made, the Do Not Attempt Cardiopulmonary Resuscitation form (Appendix 2) must be completed, recording fully the patient details, the patient's Consultant / GP, and the signature, name, position, GMC number and bleep / telephone number of the doctor completing the DNACPR order (Section 3). The DNACPR order must be communicated to nursing staff and documented in the patient's case notes/records.

A summary of the main clinical problem and reasons why CPR would be unsuccessful, inappropriate or not in the patient's best interest must be recorded in Section 1 of the DNACPR form.

A summary of communication with the patient and the patient's partner, relatives or friends (and personal welfare attorney if appointed) must be recorded in Section 2 of the DNACPR form. More detailed description of such discussions should be recorded in the clinical notes. If discussions have not taken place with the patient, relatives or friends, or with the personal welfare attorney, and they have not been informed of the decision, state clearly why this was felt to be inappropriate.

In the hospital or hospice setting, and where the DNACPR decision has been delegated to an appropriately trainee doctor, the Consultant must verbally confirm the DNACPR order at the earliest opportunity and be followed, **no later than 48 hours**, by the Consultant's signature on the DNACPR form endorsing the DNACPR decision (Section 4). Delegating responsibility does not alter the process. The entire procedure must be followed, including communication with the patient, and their relatives and friends where appropriate. In situations where responsibility has been delegated in this manner, advice and support will always be available from the Consultant on call. Wherever possible, a decision should be agreed with members of the multidisciplinary team.

3.6. Review Of DNAR Status

The decision that a patient is not to receive CPR **must never** be regarded as final. A fixed review date is not recommended although decisions about CPR must be reviewed regularly (at least at every ward round in the hospital/hospice setting and at least every 3 months in the community setting), and whenever it is clinically appropriate. This includes circumstances when there is a change in the patient's condition or in the patient's expressed wishes. It is important to note that a patient's ability to participate in decision-making may change with changes in their clinical condition.

The DNACPR order must also be reviewed whenever the patient is transferred to another Consultant or GP's care within the same or different healthcare setting (hospital, hospice or patient's home) (see 3.8). The result of each review must be recorded in the patient's

case notes/records and communicated to all staff involved in the patient's care. Any change must be communicated to the patient and/or the patient's family if appropriate.

In a hospital setting the fact that a patient is not to receive CPR must be communicated at every nursing handover so that the resuscitation status of every patient is known to every nurse on the ward. In the community setting it is recommended that where a patient has a DNACPR order in place it is discussed at the regular Primary Care Multi-Disciplinary Palliative and Supportive meetings. In addition, the fact that the patient is not to be resuscitated must be communicated to all other members of staff who may come into contact with the patient in a clinical setting both in hospital, hospice or community setting.

If there are changes in the patient's condition such that the DNACPR order is revoked, the DNACPR form should be crossed through front and back with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the doctor cancelling the order. A relevant entry informing of the change in DNACPR status, along with the reasons that brought about such cancellation, must also be made in the case notes. The original entry of the order in the case notes should also be annotated clearly to show that it has been cancelled. A new DNACPR form must be completed if the DNACPR order is reinstated.

If the patient survives to hospital discharge, the DNACPR order must either be revoked and become no longer valid, or the order must be transferred into the community setting as detailed below.

3.7. Documentation

When a DNACPR decision is made the DNACPR form (see appendix 2) must be completed, recording fully the DNACPR decision and the basis on which the decision was reached. The DNACPR form must be signed and dated by the Consultant/GP.

The DNACPR form must be filed in section 3 of the hospital case notes. In the case of a community setting the DNACPR form must be filed in the patient's home records and documented on the GP information system. Out of Hours Medical Services (Fylde Coast Medical Services, Bay Urgent Care or Preston Primary Care Centre) and North West Ambulance Service also need to be informed. An appropriate entry is required to be made in the case notes/patient home records. The entry must be legible and use clear language such as:

"IN THE EVENT OF A CARDIORESPIRATORY ARREST, CARDIOPULMONARY RESUSCITATION SHOULD NOT BE ATTEMPTED ON THIS PATIENT".

Similarly, an entry should be made in the nursing notes documenting the DNACPR order. It should indicate who made the order and the rationale behind it, and any discussions that have taken place. All subsequent reviews of the order should be documented, as should the cancellation of the order if this occurs. All entries must be clearly signed and dated. Staff are reminded that under the access to records legislation (the Data Protection Act 1998, using CORP/POL/064 (see section 7) and the Access to Health Records Act 1990 using CORP/PROC/168 (see section 7) Handling a Request for Information Personal and Non Personal) patients and, in some cases, relatives are entitled to access their medical records.

The top copy of the triplicate DNACPR form should remain in the patient's care setting at all times. This top copy should be given to the Paramedic Ambulance crew when the patient is being transferred between care settings, and left with the patient at the receiving care setting. The middle copy should be filed permanently in the care setting within which the DNACPR order was made (if in hospital, file in section 3 of the hospital case notes; if in hospice, file in the hospice case notes; and if in the community, file in the patient held District Nursing case notes). The bottom copy should be filed in the GP medical records for community and hospice patients, or forwarded to the Resuscitation Officer for DNACPR orders made in hospital.

In the event of a missing or lost DNACPR form, CPR should be started if a cardiorespiratory arrest has occurred. However, CPR should not be commenced in the community setting if the patient is on the Liverpool Care Pathway for the Dying Patient, or in circumstances when the individual shows signs of post-mortem changes such as *rigor mortis*. In the hospital or hospice setting, the medical and nursing team should refer to the patient's case notes for clarification of the DNACPR status.

3.8. Patient Transfer

Any decisions about CPR should be communicated between health professionals whenever a patient is transferred between establishments or is discharged. An active DNACPR order remains so during patient transfer by Accident and Emergency (A&E) ambulance or by the Patient Transfer Service. In particular, clear documentation must be available in the patient's case notes/records confirming that the DNACPR order has been reviewed within 48 hours in the hospital/hospice setting or within 3 months in the community setting.

If the patient remains in their own home when the DNACPR decision is made, the DNACPR form must be communicated to the North West Ambulance Service (NWAS) within 24 hours so that this service is made aware of the decision. This can be done via fax (0151 261 2666) or email (nwasnt.eolcclm@nhs.net). Similarly NWAS must also be informed when the patient is discharged from the hospital/hospice into the community with a DNACPR order in place. An active DNACPR order remains so during patient transfer by paramedic ambulance or by the Patient Transfer Service.

If the patient dies in transfer from the community to the hospital or hospice, continue the journey to the planned destination. If the transfer is from the hospital to the community, return via ambulance to the hospital via the A&E department. If the destination is to the hospice, continue the journey to the hospice. If the patient dies in transfer from the hospice to the community or hospital, return via ambulance to the hospice.

In order to ensure both continuity of care and respect for patient's views and wishes, it is imperative that when a patient's care is transferred between Consultants and GPs, any existing DNACPR order remains valid until a timely review has taken place by the most senior doctor available at the time. On transfer home from the hospital or hospice, the DNACPR order remains valid for a period of up to seven days in order to allow for a timely review by the patient's own GP, and confirm the DNACPR order by signing and dating the review section on the back of the DNACPR form. The electronic discharge summary will inform GPs of a DNACPR order made in the hospital setting. On admission of the patient into hospital as an emergency from home, an immediate review of the patient and the DNACPR order is required. In this situation, the DNACPR order should remain in place

whilst the review takes place and a new hospital DNACPR form should be completed if the order remains valid. It is important to recognise and acknowledge that the reason for the patient's acute hospital admission may be treatable and thus deserve full active management. See Appendix 3 which illustrates the flow of decision-making for patient transfer between hospital, hospice and community.

3.9. Training

Resuscitation Training will be provided as outlined in:

- Blackpool Teaching Hospitals NHS Foundation Trust Mandatory Risk Management Training Policy Corp/Pol/354 (See section 7)

- Statutory and Mandatory Training Policy, No 24 NHSB/SPD/RISK/24/2008

3.10. Clinical Audit

Experience with DNACPR decisions are the subject of clinical audit.

3.11. Process For Monitoring Compliance

The process for monitoring compliance with this procedure is identified in Appendix 4.

4. ATTACHMENTS	
Appendix 1	Decision-Making Framework
Appendix 2	DNACPR form
Appendix 3	DNACPR Flowcharts
Appendix 4	Process for Monitoring Compliance
Appendix 5	Equality Analysis Assessment Tool

5. ELECTRONIC AND MANUAL RECORDING OF INFORMATION
Electronic Database for Procedural Documents
Held by Policy Co-ordinators/Archive Office

6. LOCATIONS THIS DOCUMENT ISSUED TO		
Copy No	**Location**	**Date Issued**
1	Intranet	07/08/2012
2	Wards and Departments	07/08/2012

7. OTHER RELEVANT/ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
CORP/POL/003	Resuscitation Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-003.doc
CORP/PROC/083	Cardiopulmonary Resuscitation (CPR) Procedure http://fcsharepoint/trustdocuments/Documents/CORP-PROC-083.doc
	Trinity Hospice and Palliative Care Services Resuscitation Policy for the Adult In-Patient and Day Unit (15C).
PL/CMO(91)22	Letter from the Chief Medical Officer National Archives
CORP/POL/109	Advanced Decision / Living Will Policy

	http://fcsharepoint/trustdocuments/Documents/CORP-POL-109.doc
CORP/GUID/145	the Liverpool Care Pathway (LCP) for the Dying Patient http://fcsharepoint/trustdocuments/Documents/corp-guid-145.doc
	Patient information leaflet: Decisions About Adult CPR
CORP/POL/196	Implementing The Mental Capacity Act 2005 And Apply The Supporting Code Of Practice http://fcsharepoint/trustdocuments/Documents/CORP-POL-196.doc
CORP/GUID/083	Implementing The Mental Capacity Act 2005 And Apply The Supporting Code Of Practice http://fcsharepoint/trustdocuments/Documents/corp-guid-083.doc
CORP/POL/064	Data Protection Act 1998 http://fcsharepoint/trustdocuments/Documents/CORP-POL-064.doc
CORP/PROC/168	Handling a Request for Information Personal and Non Personal http://fcsharepoint/trustdocuments/Documents/CORP-PROC-168.doc
CORP/POL/354	Risk Management Training Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-354.docx
NHSB/SPD/RISK/24/ 2008	Statutory and Mandatory Training Policy, No 24 http://nhsblackpool/PoliciesAndProcedures/Risk%20Management%20Health%20%20Safety/Statutory%20and%20Mandatory%20Training%20Policy%20No%2024.pdf

8. SUPPORTING REFERENCES/EVIDENCE BASED DOCUMENTS
References In Full

9. CONSULTATION WITH STAFF AND PATIENTS	
Name	**Designation**
Amanda Chalk	Previous Clinical Lead for Resuscitation, BTH
Anthony Freestone	Acting Clinical Lead for Resuscitation, BTH
Dr Sarah Wenham	Community Consultant in Palliative Medicine, Trinity Hospice
Dr Michelle Martin	Macmillan GP, NHS Blackpool
David Kay	Locality Manager, NHS Blackpool
Kathryn Smith	Clinical Lead for End of Life Care, NHS Blackpool
Dr Andrea Whitfield	Hospital Consultant in Palliative Medicine, BTH
Dr Susan Salt	Medical Director, Trinity Hospice
Matron Julie Huttley	Clinical Director, Trinity Hospice
Dr Gillian Au	Macmillan GP, NHS North Lancashire (Fylde & Wyre)
Dr Peter Nightingale	Macmillan GP, NHS North Lancashire (Morecambe & Lancaster)
Karen Hodgson	Clinical Training Manager, NHS North Lancashire
Steve Barnard	Clinical Governance Lead, North West Ambulance Service

10. DEFINITIONS/GLOSSARY OF TERMS	

11. AUTHOR/DIVISIONAL/DIRECTORATE MANAGER APPROVAL			
Issued By	Dr Jason Cupitt	**Checked By**	Dr N Randall
Job Title	Consultant Anaesthetist	**Job Title**	Divisional Director
Date	August 2012	**Date**	August 2012

Appendix 1: Decision-Making Framework

Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?

NO → If there is no reason to believe that the patient is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with the patient (or those close to patients who lack capacity) about CPR. If, however, the patient wishes to discuss CPR this should be respected.

YES

Is there a realistic chance that CPR could be successful?

NO → When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient's wishes about CPR, but careful consideration should be given as to whether to inform the patient of the DNACPR decision. **Ideally they should be informed.**
Where the patient lacks capacity and has a personal welfare attorney, this person (and also the family/relatives) must be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussion about the patient's care. If a second opinion is requested, this request should be respected, whenever possible.

YES

Does the patient lack capacity and have an advance decision refusing CPR or a personal welfare attorney with relevant authority?

YES → If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, this must be respected. If a personal welfare attorney has been appointed they must be consulted.

NO

Are the potential risks and burdens of CPR considered to be greater than the likely benefit of CPR?

YES → When there is only a small chance of success, and there are questions about whether the burdens outweigh the benefits of attempting CPR, **the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial**. When adult patients have mental capacity their own view should be taken into account when making the decision.

NO

CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.

Appendix 2: Do not attempt Cardiopulmonary Resuscitation (DNACPR) Form

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Blackpool Teaching Hospitals NHS Foundation Trust

FILE IN SECTION 3

Date and time of DNACPR order

.....

Consultant/GP

.....

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

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

Reason for DNACPR order. Tick the appropriate box(es): SECTION 1

- ☐ The patient's condition indicates that CPR would not be successful .....
- ☐ CPR is not in accordance with the wishes of a patient who is mentally competent and has capacity
- ☐ CPR is not in accordance with a valid and applicable advance decision to refuse treatment
- ☐ Successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain .....
- ☐ CPR is not in accordance with the wishes of a person properly authorised to make decisions regarding life-sustaining treatment on behalf of the patient under the Mental Capacity Act
- ☐ The patient has been commenced on the Liverpool Care Pathway for the Dying Patient

Summary of discussions: SECTION 2

Has the patient been involved in the discussion?	YES ☐ NO ☐
Has the patient been informed of the decision?	YES ☐ NO ☐
Has the patient agreed for the decision to be discussed with the partner, relatives or friends?	YES ☐ NO ☐
Has the patient's partner, relatives or friends been involved in the discussion?	YES ☐ NO ☐
Has the patient's partner, relatives or friends been informed of the decision?	YES ☐ NO ☐

Names and relationships of relevant others involved in discussions .....

Has a Lasting Power of Attorney been involved in the discussion and/or informed of the decision? YES ☐ NO ☐

If no discussions have taken place with the patient or relevant others, state why not .....

Doctor making the DNACPR order: SECTION 3

Signature ..... Print name ..... GMC Number .....

Position ..... Bleep no (hospital) ..... Contact no (community) .....

Date ...../...../..... Time .....

FOR HOSPITAL/HOSPICE DNACPR ORDERS Endorsement by the Consultant within 48 hours: SECTION 4

Consultant signature ..... Print name ..... GMC Number .....

Date ...../...../..... Time ..... Bleep number .....

Prior to hospital/hospice discharge or community DNACPR orders: SECTION 5

Inform NWAS via fax 0151 261 2666 ☐ or email nwasnt.eolcclm@nhs.net ☐

Ambulance crew instructions SECTION 6

DNACPR order reviewed prior to transfer: within 48 hours (hospital/hospice) ☐ within 3 months (community) ☐

If, whilst in transit, the patient: suddenly deteriorates - continue journey to destination
dies - take to destination as per instructions overleaf

Top copy: To be kept with documentation in patient's care setting. Give to ambulance personnel if patient transferred and file in notes at patient's destination.
Middle copy: File in patient's case notes (hospital/hospice) or handheld district nursing notes (community)
Bottom copy: Forward to Resuscitation Office (hospital patients only) or GP (community patients)

V5932 (B4) 10/12 Approved by the Health Records Committee 10/08/2012 Procedural Document ID: Corp/Proc/003

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FORM

Consider using this form (as part of Advance Care Planning) if you would not be surprised if the patient was to die in the next year.

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

- The person's full name, date of birth, NHS or hospital number and address should be completed and written clearly.
- The date and time of writing the order must be entered.
- The order will be regarded as "INDEFINITE" unless it is clearly cancelled.
- The order should be reviewed whenever clinically appropriate or whenever the patient's care is transferred between clinicians and/or healthcare institutions.
- 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 senior doctor cancelling the order. It is the responsibility of the doctor cancelling the DNACPR order to communicate this to all parties.

1. Summary of the main clinical problem and reasons why CPR would not be successful, would be inappropriate or not in the patient's best interests. Be as specific as possible and include relevant free text. Tick more than one box if relevant.

2. Patient's should be involved in discussions about their care and informed of decisions that have been made. If the patient has capacity then they should consent to discussions with their relatives/friends. If the patient lacks capacity then their relatives/friends should be involved in discussions about the patient's care and informed of decisions that have been made. They may be able to help by indicating what the patient would want. If the person has appointed a personal welfare attorney to make decisions on their behalf, that person must be consulted.

   Check the validity and applicability of any advance decision to refuse treatment, particularly if this is a written document and whether it contains specific circumstances detailing resuscitation.

   State the names and relationships of relatives or friends or relevant others with whom discussions have taken place. More detailed description of such discussions should be recorded in the clinical notes.

   If discussions have not taken place with the patient, relatives or friends, and they have not been informed of the decision, state clearly why this was felt to be inappropriate.

3. Complete all parts in full. This should be the most senior doctor on duty.

4. All DNACPR orders in the hospital/hospice must be confirmed verbally by the Consultant in charge of the patient's care at the earliest opportunity. The order must then be endorsed by the Consultant, in writing, within 48 hours.

5. North West Ambulance Service (NWAS) must be informed when patients are discharged from the hospital/hospice into the community with a DNACPR order, or when a DNACPR order is made in the community.

6. **Ambulance crew instructions:**
   For the DNACPR order to be valid, it must have been reviewed within the previous 48 hours of the patient being discharged from the hospital/hospice or within the last 3 months for community patients (see box below).

   What to do if the patient dies in transit

   From community:
   - To hospital or hospice, continue journey to planned destination

   From hospital:
   - On discharge to community, return via ambulance to hospital via A&E department
   - On transfer to hospice, continue journey to hospice

   From hospice:
   - On discharge to community, return via ambulance to hospice
   - On transfer to hospital, return via ambulance to hospice

FOR COMMUNITY PATIENTS ONLY – review by GP that DNACPR order remains valid (review within 7 days of hospital/hospice discharge and at least every 3 months)

Name: ..... Signature: ..... Position: ..... GMC No: ..... Date: ..../..../....

Name: ..... Signature: ..... Position: ..... GMC No: ..... Date: ..../..../....

Name: ..... Signature: ..... Position: ..... GMC No: ..... Date: ..../..../....

Name: ..... Signature: ..... Position: ..... GMC No: ..... Date: ..../..../....

Name: ..... Signature: ..... Position: ..... GMC No: ..... Date: ..../..../....

Name: ..... Signature: ..... Position: ..... GMC No: ..... Date: ..../..../....

Appendix 3: Do not attempt Cardiopulmonary Resuscitation (DNACPR) Flowcharts

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

TRINITY

INTEGRATED DNACPR PROCEDURE
HOSPITAL / HOSPICE DNACPR FLOWCHART

DNACPR DECISION MADE IN HOSPITAL OR HOSPICE

Most senior doctor available completes DNACPR form
Top copy to be kept in hospital / hospice notes until patient discharged
Middle copy to be filed in hospital / hospice notes
Bottom copy to be sent to Resuscitation Officer (hospital patients) or GP (hospice patients)

&

Doctor annotates medical records

PATIENT ADMITTED TO HOSPITAL OR HOSPICE WITH VALID DNACPR ORDER

Top copy of DNACPR form comes with patient

Most senior doctor available reviews patient IMMEDIATELY on arrival in hospital or hospice

DNACPR ORDER REMAINS VALID

Doctor writes 'CANCELLED' through front and back of community DNACPR form
&
Cancelled DNACPR form filed in medical records
&
Doctor completes new DNACPR form
&
Doctor annotates medical records

DNACPR ORDER REVOKED

Doctor writes 'CANCELLED' through front and back of community DNACPR form

&

Cancelled DNACPR form filed in medical records

&

Doctor annotates medical records

COMMUNICATION OF HOSPITAL DNACPR DECISION
Doctor completing form informs ward nursing staff of DNACPR status

CONSULTANT ENDORSEMENT OF HOSPITAL/HOSPICE DNACPR DECISION
Consultant verbally confirms DNACPR decision at the earliest opportunity
Consultant signs DNACPR form not later than 48 hours after the decision is made

REVIEW OF HOSPITAL/HOSPICE DNACPR DECISION
Consultant reviews DNACPR status on at least every ward round
& annotates medical records

IF PATIENT TRANSFERRED HOME VIA AMBULANCE
Doctor reviews DNACPR order within 48 hrs prior to transfer
& annotates medical records
Ambulance crew ensures DNACPR order is valid and take top copy on transfer
North West Ambulance Service (NWAS)
Fax form to 0151 261 2666 or email nwasnt.eolcclm@nhs.net
If patient deteriorates or dies in transit,
ambulance crew follow instructions on back of DNACPR form
Doctor informs GP of DNACPR status on discharge summary

ON ARRIVAL OF PATIENT AT HOME
Ambulance crew leave DNACPR form at home to be kept with patient
DNACPR form completed in hospital/hospice is valid for 7 days following discharge
Patient reviewed by GP within 7 days,
and DNACPR form reviewed in accordance with community flowchart

INTEGRATED DNACPR PROCEDURE
COMMUNITY DNACPR FLOWCHART

DNACPR DECISION MADE IN COMMUNITY BY GP

GP completes DNACPR form
Top copy to be kept with patient
Middle copy to be filed in District Nursing notes
Bottom copy to be filed in GP notes

&

GP annotates & codes patients medical records

PATIENT DISCHARGED FROM HOSPITAL OR HOSPICE WITH VALID DNACPR ORDER
GP informed of DNACPR order via hospital discharge summary

Top copy of DNACPR form comes home and to be kept with patient

DNACPR form completed in hospital/hospice is valid for 7 days following discharge

GP reviews patient within 7 days of discharge

DNACPR ORDER REMAINS VALID

GP signs back of DNACPR form
&
GP annotates & codes medical records

DNACPR ORDER REVOKED BY GP

GP writes 'CANCELLED' through front and back of hospital/hospice DNACPR form

&

GP files cancelled DNACPR form in GP notes

&

GP annotates medical records & reviews code

COMMUNICATION OF COMMUNITY DNACPR DECISION
GP informs:
Community Nursing Team
NHS Blackpool – by e-mail on communitynursingcrs@blackpool.nhs.uk
NHS North Lancs – by e-mail to district nursing team leader
Out of Hours Medical Service
Fylde Coast Medical Services – electronically via ADASTRA
Bay Urgent Care – electronically via ADASTRA and fax form to 01524 405750
Preston Primary Care Centre – fax form to 01772 712634
North West Ambulance Service (NWAS)
Fax form to 0151 261 2666 or email nwasnt.eolcclm@nhs.net
GP informs MDT of DNACPR status at Palliative & Supportive Care / GSF

GP reviews DNACPR order at least every three months
GP signs back of DNACPR form & GP annotates medical records

IF PATIENT TRANSFERRED TO HOSPITAL OR HOSPICE VIA AMBULANCE

Ambulance crew ensures DNACPR order is valid and take top copy on transfer

If patient deteriorates or dies in transit, ambulance crew follow instructions on back of DNACPR form

ON ARRIVAL OF PATIENT IN HOSPITAL OR HOSPICE
Ambulance crew give DNACPR form to hospital or hospice staff
Patient reviewed by medical staff IMMEDIATELY on arrival in hospital / hospice, and DNACPR form reviewed in accordance with hospital / hospice flowchart

Appendix 4: Process for Monitoring Compliance

Minimum requirement to be monitored		Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
a)	Requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured, including the frequency of measurement	Audit	Resuscitation Officer/Outreach Team Leader Clinical Audit Team	Annual	Resuscitation Officer/ Outreach Team Leader / Care of the Acutely Ill Group / Resuscitation Committee	Resuscitation Officer/ Outreach Team Leader / Care of the Acutely Ill Group / Resuscitation Committee	Resuscitation Officer/ Outreach Team Leader / Care of the Acutely Ill Group / Resuscitation Committee
b)	Use of an early warning system within the organisation to recognise patients at risk of deterioration	Audit	Outreach Team Leader/Clinical Audit Team	Annual	Outreach Team Leader / Care of the Acutely Ill Group / Resuscitation Committee	Outreach Team Leader / Care of the Acutely Ill Group / Resuscitation Committee	Outreach Team Leader / Care of the Acutely Ill Group / Resuscitation Committee
c)	Actions to be taken to minimise or prevent further deterioration in patients	Audit	Resuscitation Officer/ Clinical Audit Team	Annual	Resuscitation Officer / Care of the Acutely Ill Group / Resuscitation Committee	Resuscitation Officer / Care of the Acutely Ill Group / Resuscitation Committee	Resuscitation Officer / Care of the Acutely Ill Group / Resuscitation Committee
d)	Do not attempt resuscitation orders (DNAR)	Audit	Resuscitation Officer/ Clinical Audit Team	Annual	Resuscitation Officer/ Care of the Acutely Ill Group / Resuscitation Committee	Resuscitation Officer / Care of the Acutely Ill Group / Resuscitation Committee	Resuscitation Officer Care of the Acutely Ill Group / Resuscitation Committee
e)	How the organisation documents that resuscitation equipment is checked, stocked and fit for use	Audit	Resuscitation Officer/ Clinical Audit Team	Annual	Learning and Development Manager/HR & OD Teaching Governance Committee	Learning and Development Manager/HR & OD Teaching Governance Committee	Learning and Development Manager/HR & OD Teaching Governance Committee
f)	How the organisation monitors compliance with all of the above	Audit	Learning and Development Manager	Annual	Learning and Development Manager/Human Resources and Organisational Development Governance Committee	Learning and Development Manager/Human Resources and Organisational Development Governance Committee	Learning and Development Manager/Human Resources and Organisational Development Governance Committee

Appendix 5: Equality Impact Assessment Tool

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Would the relevant Equality groups be affected by the document? (If Yes please explain why you believe this to be discriminatory in Comment box)
Title & Identification Number of the Document: Do not attempt Cardiopulmonary Resuscitation (Adults, including Community Services) Corp/Proc/003

	Questionnaire	Yes/No Double click and select answer	Comments
1	Grounds of race, ethnicity, colour, nationality or national origins e.g. people of different ethnic backgrounds including minorities: gypsy travellers and refugees / asylum seekers.	No	
2	Grounds of Gender including Transsexual, Transgender people	No	
3	Grounds of Religion or belief e.g. religious /faith or other groups with recognised belief systems	No	
4	Grounds of Sexual orientation including lesbian, gay and bisexual people	No	
5	Grounds of Age older people, children and young people	No	
6	Grounds of Disability: Disabled people, groups of physical or sensory impairment or mental disability	No	
7	Is there any evidence that some groups are affected differently?	No	
8	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
9	Is the impact of the document/guidance likely to be having an adverse/negative affect on the person (s)?	No	
10	If so can the negative impact be avoided?	N/A	

11	What alternatives are there to avoid the adverse/negative impact?	**Please Comment**	
12	Can we reduce the adverse/negative impact by taking different action?	N/A	**Please Identify How**

13 Q1 (a) **Is the document directly discriminatory?** No (under any discrimination legislation) • Racial Discrimination • Age Discrimination • Disability Discrimination • Gender Equality • Sexual Discrimination	**Q2 (b) (i)** Is the document indirectly discriminatory? No **b (ii)** If you said yes , is this justifiable in meeting a legitimate aim N/A	**Q3 (c)** Is the document intended to increase equality of opportunity by positive action or action to redress disadvantage N/A Please give details To safeguard vulnerable adults

14 If you have answered **no** to all the above questions **1-13** and the document does not discriminate any Equality Groups please go to **section 15**

If you answered **yes** to Q1 (a) and **no** to Q3 (b) this is unlawful discrimination.

If you answered **yes** to Q2 (b) (i) **no** to Q2 (b) (ii) and **no** to Q3 (c), this is unlawful discrimination

If the content of the document is not directly or indirectly discriminatory, does it still have an adverse impact?

No

Please give details

If the content document is unlawfully discriminatory, you must decide how to ensure the organisation acts lawfully and amend the document accordingly to avoid or reduce this impact

15 Name of the Author completing the Equality Impact Assessment Tool.

Name Dr Jason Cupitt

Signature

Designation Consultant Anaesthetist

Date July 2012