Do Not Attempt Cardiopulmonary Resuscitation

Adult Policy for

Central and Eastern Cheshire Primary Care

and Community Services

Date: June 2012

Version 2.0

This policy is based on the East Cheshire NHS Trust DNACPR Policy and GMCCN Draft Guidance.
<table>
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<th><strong>Adult Do Not Attempt Cardiopulmonary Resuscitation (East Cheshire NHS Trust Community Version)</strong></th>
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<tr>
<td><strong>Executive Summary</strong></td>
<td>This Community DNACPR Policy supports General Practitioners (GPs) and community professionals who are actively engaged in the care of adult patients known to be in the last months of their life. It facilitates timely documentation and communication of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for adult patients within the last twelve months of life. It increases the likelihood of the patient dying in the place of their choosing and avoids futile resuscitation attempts. Developing best practice in DNACPR decision-making in the Central and Eastern Cheshire area informs progression to an integrated DNACPR policy. This will support patients and professionals at all times, irrespective of the care setting within which they find themselves. Readers are urged to consider the full policy and the compliance monitoring tool, given the very serious nature of the decisions being made. This policy reflects the core principles outlined by the General Medical Council (GMC 2010) in their guide: Treatment and care towards the end of life: good practice in decision making, and should be used as a ready reference guide <a href="http://www.gmc-uk.org/End_of_life.pdf_32486688.pdf">http://www.gmc-uk.org/End_of_life.pdf_32486688.pdf</a></td>
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<td>Version 1.0</td>
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<td><strong>Description of amendments</strong></td>
<td>Review period is regarded as ‘INDEFINITE’ unless specific date given. Section 7.5 on CARE HOMES added for clarity. Notification form added (Appendix 4). Wording changed from ‘VOID’ to ‘CANCELLED’. Decision-making framework (Appendix 10) added. Compliance monitoring toolkit has replaced previous KPIs.</td>
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<td><strong>This policy will impact upon</strong></td>
<td>Adult patients in East and Central Cheshire PCT area GP Practices and Community Services operating within the Vale Royal Clinical Commissioning Group, East Cheshire Clinical Commissioning Group, South Cheshire Health</td>
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<td>Community &amp; Primary Care DNACPR Sub-Committee</td>
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### Abbreviations & Definitions

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<tr>
<td>ACP</td>
<td>Advance Care Planning</td>
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<td>ADRT</td>
<td>Advance Decision to Refuse Treatment</td>
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<td>An advance decision enables someone aged 18 and over, while still has capacity, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.</td>
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<td>AND</td>
<td>Allow Natural Death</td>
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<td>CCGs</td>
<td>Clinical Commissioning Groups</td>
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<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
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<td>DNACPR</td>
<td>Do Not Attempt Cardiopulmonary Resuscitation</td>
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<td>ECT</td>
<td>East Cheshire NHS Trust</td>
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<td>EOL</td>
<td>End of Life</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>GSF</td>
<td>Gold Standard Framework</td>
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<td>ICPDA</td>
<td>Integrated Care Pathway for the Dying Adult</td>
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<td>LCP</td>
<td>Liverpool Care Pathway for the Dying Patient</td>
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<td>LPA (H&amp;W)</td>
<td>Lasting Power of Attorney (Health &amp; Welfare)</td>
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<td>MCHFT</td>
<td>Mid Cheshire Hospital Foundation Trust (Leighton)</td>
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<td>MDGH</td>
<td>Macclesfield District General Hospital</td>
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<td>NEoLCP</td>
<td>National End of Life Care Programme</td>
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<td>NWAS</td>
<td>North West Ambulance Service</td>
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<td>PPC</td>
<td>Preferred Priorities for Care</td>
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<td>RMG</td>
<td>Risk Management Group</td>
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<td>SQS</td>
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1.0 Introduction
This DNACPR Policy supports General Practitioners (GPs) and community professionals who are actively engaged in the care of adult patients known to be in the last months of their life. The project is a joint collaboration with North West Ambulance Service (NWAS). It enables timely documentation and communication of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for adult patients within the last twelve months of life. It increases the likelihood of the patient dying in the place of their choosing and avoids futile resuscitation attempts. Developing best practice in DNACPR decision-making in the Central and Eastern Cheshire area informs progression to an integrated DNACPR policy. This will support patients and professionals at all times, irrespective of the care setting within which they find themselves.

This introductory section provides a quick reference guide. It is not designed to be read in isolation from the rest of the DNACPR policy, and readers are urged to consider the full policy given the very serious nature of the decisions being made. This policy reflects the core principles outlined by the General Medical Council (GMC 2010) in their guide: Treatment and care towards the end of life: good practice in decision making, and which should be used as a ready reference guide http://www.gmc-uk.org/End_of_life.pdf_32486688.pdf

1.1 Policy Guidance
A copy of the Community DNACPR policy must be readily available to and understood by all community and primary care staff involved in direct patient care. Collective responsibility is held by the CCGs to follow the policy, and responsibility also lies with the individual GPs to adhere to the specific guidance upheld therein. Further information and training can be sought through contacting the East Cheshire Trust Community Business Unit Services Managers, or the Macmillan End of Life Care Team Leader or Lead Facilitator. The bullet points in section 1 are intended to highlight some of the main points arising from the DNACPR policy.

1.2 Medical Prediction of the likely outcome of CPR
- Decisions about CPR must be made on the basis of an individual assessment of each patient’s case.
- It is not necessary to discuss CPR decisions with all patients. This policy focuses on those at risk.
- Advance care planning, including making decisions about CPR, is an important part of good clinical care for those known to be in the last year of life.

1.3 Presumption in favour of CPR
- Where no explicit decision has been made in advance there should be an initial presumption in favour of CPR.
1.4 Scope of DNACPR

- A DNACPR decision should be considered for all patients on the Gold Standard Framework (GSF) register, or who have a palliative diagnosis.
- DNACPR decisions apply only to CPR and not to any other aspects of treatment.
- 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.

1.5 Balancing benefits of CPR with the Burdens of Disease

- Where the expected benefit of attempted CPR may be outweighed by the burdens, the patient’s informed views are of paramount importance. If the patient lacks capacity, those close to the patient should be involved in discussions to explore the patient’s wishes, feelings, beliefs and values.

1.6 Mental Capacity

- If a patient with capacity refuses CPR in advance, or if the patient lacking capacity has a valid and applicable Advance Decision to Refuse Treatment (ADRT) refusing CPR, this should be respected. Further guidance on ADRTs can be obtained from: http://www.endoflifecareforadults.nhs.uk/publications/pubadrtguide
- If a patient without capacity has appointed a Lasting Power of Attorney (Health and Welfare) they may legally make the decision in favour of DNACPR, but cannot insist on CPR.

1.7 Decisions not to initiate CPR

- If CPR would not re-start the heart and breathing, i.e.: the patient has clearly died a length of time before being discovered, CPR should not be attempted.
- Where there is considered no benefit in restarting the patient’s heart and breathing, i.e. if the patient is terminally ill and death is inevitable within a short period of time, then that person should be allowed to die naturally with full comfort and palliative measures.

1.8 Circumstances where the risk of cardiopulmonary arrest is increased

- A DNA-CPR decision does not override clinical judgement if there is an immediately reversible cause of the patient’s respiratory or cardiac arrest e.g.: choking on an item of food; anaphylaxis.

1.9 Responsibility for the DNACPR decision

- The primary responsibility concerning the making and recording of a DNACPR decision lies with the GP who has medical responsibility for the patient at the time.
1.10 Discussing DNACPR

- While it is considered best practice to discuss DNACPR decisions in advance with patients, there may be occasions where this discussion may be unnecessary and not in the best interests of the patient, i.e. when a patient is in the last days and hours of life and on the Integrated Care Pathway for the dying adult (ICPDA).

- The model patient information leaflet (appendix 6) should be used to support DNACPR discussions with both patients and their relatives where appropriate.

- Where possible members of the multi-professional team involved in the patient’s care should be consulted in the DNACPR decision making process.

1.11 Documentation

- DNACPR decisions should be documented on the patient held NWAS Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decision form (appendix 3). Entry into the patient’s medical notes is a legal requirement, be this the electronic record or paper copy of the notes. Record into the community nursing notes is also necessary if the patient is known to the community nursing service.

- Where the ICPDA is in place this documentation represents a DNACPR decision. It is not therefore necessary to complete a separate DNACPR form.

1.12 Communication

- When a DNACPR decision is made this must be communicated to all members of the multi-professional team involved in the patient’s care including ‘Out of Hours’ GP and nursing services preferably by secure email or fax.

- NWAS should be informed of the presence of a DNACPR decision using the notification form detailed in appendix 4.

1.13 Review

- The frequency of review is the clinical decision of the GP. If the death is expected and resuscitation attempts would be futile, the default position would be to document ‘Indefinite’.

- A DNACPR decision should be kept under review - particularly if there is a change in the clinical state of the patient, or if a review is requested by the patient or those close to them, or any member of the healthcare team.

- In line with best practice it is regarded as necessary to consider the decision every twelve months.

- The review date of a DNACPR decision should be carefully considered, as this also has serious implications for keeping other services informed. Where the decision has changed, this must be communicated to other services within 24 hours of the review.
If a specific review date is given, in order to remain valid the DNACPR decision must be within the date indicated on the form. If the review date is passed and therefore no longer valid, healthcare professionals would be obliged to carry out CPR.

2.0 Policy Statement

2.1 Cardiopulmonary resuscitation may be attempted on any individual for whom cardiac or respiratory function ceases. Such events are inevitable as part of dying. CPR can theoretically be used on every individual prior to death. However, in some people this would be inappropriate, futile or against the individual’s wishes. It is therefore essential to distinguish those patients for whom CPR would be inappropriate. Some patients who have capacity may wish to make an advance decision to refuse treatment which is legally binding but has to meet specific criteria (see appendix 1). These statements must be respected as long as these decisions are informed, current and made without coercion from others.

2.2 Policy Aim

The overall aim of this Community DNACPR policy is to support community professionals who are actively engaged in the care of patients known to be in the last months of their life. This document will be circulated to all GPs and Community Nursing Teams within the Vale Royal Clinical Commissioning Group, South Cheshire GP Commissioning Consortium and East Cheshire Commissioning. The policy will provide guidance to those healthcare professionals who are:

- involved in considering and documenting the DNACPR decision of patients,
- caring for patients with a DNACPR decision,
- supporting patients who have an ADRT that includes refusing CPR,
- caring for patients at the end of life,
- communicating DNACPR decisions across the multi-professional team.

2.3 Policy Objectives

The objectives within this policy are to:

- Encourage timely consideration, documentation and communication of DNACPR decisions, particularly for those patients whose care is palliative and/or who are on the GSF register.
- To avoid inappropriate resuscitation attempts.
- To ensure that decisions regarding CPR are made according to:
  - whether CPR could succeed,
  - the clinical needs of the patient,
  - the patient's wishes and best interests,
  - current ethical principles,
- current legislation such as the Human Rights Act (1998), and the Mental Capacity Act (2005).
- To make DNACPR decisions transparent and open to examination.
- To make DNACPR decisions which are tailored to the individual circumstances of the patient.
- To clarify DNACPR situations for clinical staff caring for people who have communication difficulties and other vulnerable groups.
- To ensure patients, relevant others and staff have information on making decisions about resuscitation and that they understand the process.
- To encourage and facilitate open, appropriate and realistic discussion with patients and their relevant others about resuscitation issues, and not burden them with having to make a decision regarding resuscitation.
- To ensure that a DNACPR decision is communicated to all relevant healthcare professionals and services involved in the patient's care.

3.0 Background
3.1 The factors surrounding a decision whether or not to initiate CPR involve complex clinical considerations and emotional issues. The decision for CPR of one patient may be inappropriate in a superficially similar case and should be made specifically for each individual.

3.2 In conjunction with the GMC, a joint statement by the BMA, the Royal College of Nursing and the Resuscitation Council (UK) was issued in October 2007\(^1\). New recommended standards for recording DNACPR were issued in 2009 by the Resuscitation Council\(^2\). These guidelines have been used to prepare this document. This policy represents the individual’s absolute right to life in accordance with the Human Rights Act (1998), and the Mental Capacity Act (2005)\(^3\).

3.3 Copies of this policy will be circulated to Central and Eastern Cheshire GPs and Community Services teams within East Cheshire NHS Trust and made available on the Trust Intranet site. Information leaflets are available to all who may wish to consult them, including patients, families and carers (Decisions about Cardiopulmonary Resuscitation – [www.resus.org.uk/pages/deccprmd.pdf](http://www.resus.org.uk/pages/deccprmd.pdf)).

4.0 Organisational Responsibilities
4.1 Chief Executive of East Cheshire NHS Trust
Has ultimate responsibility for the implementation and monitoring of this policy. This responsibility may be delegated - for example, the Medical Director.
4.2 Clinical Commissioning Leads
The GP Clinical Commissioning Boards are responsible for the implementation of this policy within
GP Practices. The individual GPs making the DNACPR decisions are responsible for informing
NWAS and Community Services staff when a DNACPR decision is in place.

4.3 Lead Nurse Community Business Unit & End of Life Care Team Leader
4.3.1 Locality Manager South & Vale Royal, ECT Community Business Unit along with the End of
Life Care Team Leader, and End of Life Care Lead Facilitator are responsible for ensuring that
relevant community staff have access to the policy and are trained in its implementation and
application to practice. This relates specifically to the District Nurse Team Leaders and the Out Of
Hours GP and District Nursing Service in the three GP Commissioning Groups who are
responsible for reading and applying the policy within the scope of their clinical practice.

4.3.2 The point of contact for any arising queries related to the pilot project is:
- Locality Manager South & Vale Royal, Community Business Unit ECNHST
- End of Life Care Team Leader & End of Life Care Lead Facilitator

4.4 The Community and Primary Care DNACPR Sub-Committee
The Community and Primary Care DNACPR Sub-Committee is responsible for the development,
consultation and approval of this policy. It consists of representatives from Primary
Care, Community Services, NWAS and the East Cheshire NHS Trust Resuscitation Committee. Its
function is to develop and take forward future DNACPR initiatives in primary care. The Community
and Primary Care DNACPR Sub-Committee will be responsible for reviewing the community policy
and to ensure that it follows the latest best practice guidance.

5.0 Application
5.1 Medical Prediction of the Outcome of Resuscitation
5.1.1 Unfortunately many patients have unrealistic expectations of the success of CPR and
potential complications and consequences. Medical prediction of the outcome of resuscitation
should be as realistic as possible and take into account the clinical condition of the patient, the
likely cause of the anticipated arrest and the environment within which the patient is being cared.
Explanations of the probability of survival can significantly influence the resuscitation choices of
older patients.

5.1.2 If a patient or a LPA (H&W) is requesting CPR in the case of a cardio-respiratory arrest, but
the healthcare team believes that this would not re-start the heart and breathing, this should be
explained to the patient or LPA (H&W) proxy decision-maker in a sensitive way. These
discussions may be difficult, and where possible should be carried out by experienced clinicians. If the decision is not accepted, a second opinion should be offered.

5.2 Presumption to resuscitate

5.2.1 For many patients the likelihood of cardio-respiratory arrest is small and no clinical decision is made in advance of such an event. If cardio-respiratory arrest does occur unexpectedly, CPR should be attempted.

5.2.2 When no explicit decision has been made about resuscitation before cardio-respiratory arrest, and the express wishes of the patient are unknown, it should be presumed that staff would attempt to resuscitate the patient. Although this should be the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is clearly in the terminal phase of an illness. If CPR would not re-start the heart and breathing, i.e. if the patient has clearly died a length of time before being discovered, it should not be attempted.

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.

Medical or experienced nursing staff, are therefore not obliged to initiate resuscitation measures for a patient where the death is clearly expected and due to an irreversible illness such that CPR would be unsuccessful and unquestionably inappropriate. A DNACPR decision making form is contained within the ICPDA.

5.2.3 Where there is considered no benefit in restarting the patient’s heart and breathing, i.e. if the patient is terminally ill and death is inevitable within a short period of time, then that person should be allowed to die naturally with full comfort and palliative measures.

5.2.4 Any CPR decision must be tailored to the individual circumstances. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Blanket policies that deny CPR to groups of patients are considered unethical.
5.3  Risk of cardiopulmonary arrest
In some people there is an identifiable risk of cardiac or respiratory arrest, such as an underlying incurable condition (such as advanced cancer), the history (such as recent myocardial infarction or stroke), or current clinical condition (such as severe sepsis). If there is a risk of cardiac or respiratory arrest a decision should be made in advance about the appropriateness of CPR whenever possible.

5.4  Scope of DNACPR
5.4.1 A DNACPR decision (see NWAS form, appendix 3) applies only to patients who are being cared for in their usual place of residence. If the patient is in temporary respite, e.g.: Hospice. DNACPR decisions should be documented as per the protocol of the organisation within which the patient is resident. Likewise patients in the acute care setting of MDGH or MCHFT would need to have DNACPR decisions recorded on the acute Trust’s specific documentation.

5.4.2 The NWAS DNACPR form can be used in the event of a patient needing transportation to and from hospital or hospice, and in the event of a rapid discharge where the ICPDA is not in place.

5.4.3 No other treatment or care shall be precluded or be influenced by a DNACPR decision.

5.5  Adult patients with capacity
5.5.1 Patients with capacity are able to understand their situation and the consequences of their decisions. Adults should be presumed to have capacity unless there is evidence to the contrary. If there is any doubt whether the patient has capacity – for example, if they have learning difficulties, dementia or are vulnerable and may be under the influence of others - a formal assessment of capacity should be made. An assessment of capacity should relate to the specific decision the patient is being asked to make and their ability to fully comprehend their situation and the implications of their decision.

5.5.2 Assessment of capacity can be undertaken by any professional caring for the patient who has understanding of the principles of the Mental Capacity Act (2005)\(^3\) and are working within the patient’s best interests. This assessment needs to be documented in the medical and nursing notes and communicated to the multidisciplinary team involved in that patient’s care. If the patient has capacity to make this decision:
- discuss the options with the patient unless they make it clear they do not wish to have this discussion,
- continue to communicate the rationale for any decisions made with the patient and relevant others if the patient agrees,
document the rationale for any DNACPR decisions that may be made without consulting the patient, i.e. for the patient who is on the ICPDA.

5.6 Adult patients who lack capacity

5.6.1 Patients who are judged to lack capacity to make decisions should be managed under the principles of the Mental Capacity Act 2005.

5.6.2 The GMC (2010) give clear guidance about this in Section 140 and 141.

5.6.3 For the patient who does not have capacity to make this decision:

- Enquire with relevant others about any previous wishes expressed by the patient that may help the clinical team to make the most appropriate decision,
- Check if someone has been appointed as a LPA (H&W). Proxies under a LPA (H&W) can only make decisions about life-sustaining treatment if the person has given them express power to do so, but cannot demand treatment that is clinically inappropriate. Clinical staff need to see the documentation, LPA (Health & Welfare), and it must have been validated by the Office of the Public Guardian (http://www.direct.gov.uk/en/Governmentcitizensandrights/Mentalcapacityandthelaw/Mentalcapacityandplanningahead/DG_186373)
- Continue to communicate the rationale for any decisions made at all times with the appropriate people,
- Document any discussion in the medical and nursing notes detailing the circumstances that any decision relates to and who was involved in the decision making process,
- Complete DNACPR form if appropriate,
- Review regularly and if circumstances change.

5.6.4 Adults who lack capacity and have neither an attorney nor an ADRT but do have a family or friend

In this situation the treatment decision rests with the patient’s GP. The decision should always be made in the patient’s best interest and the views of those close to the patient should be sought wherever possible, to determine any previously expressed wishes.

5.6.5 Adults who lack capacity have no family, friend or other advocate whom it is appropriate to consult

In this situation the Mental Capacity Act (2005)³ requires an Independent Mental Capacity Advocate (IMCA) to be consulted about all serious medical treatment decisions. Where it is clear to the medical team that CPR would not re-start the patient’s heart and breathing for a sustained period an IMCA does not need to be called in. However, where there is genuine doubt about this, an IMCA must be involved to comply with the law. See http://www.ageuk.org.uk/cheshire/Our-services/Advocacy/ for guidance on obtaining an IMCA in Cheshire.
5.7 The decision not to undertake CPR
The decision not to attempt CPR on a patient should be taken following appropriate consideration of the likely clinical outcome and the patient’s known wishes. The decision-making framework in appendix 10 and the following guidelines may support a decision not to attempt CPR:

5.7.1 Where attempting CPR would not restart the patient’s heart and breathing
The GP should make a clinical assessment of the patient’s condition on the basis of current medical knowledge and clinical guidelines (where available) and in the patient’s best interests. If the GP is as certain as possible that attempting CPR in the case of a cardio-respiratory arrest would not restart the patient’s heart and breathing then it should not be attempted.

5.7.2 Where the expected benefit is outweighed by the burdens of resuscitation
Where CPR may be successful in restarting the patient’s heart and breathing, and thus prolong the patient’s life, the benefits to be gained from the prolongation of life must be weighed against the burdens to the patient of the treatment. Again, this should be a team decision based on clinical assessment of the patient’s condition and current clinical guidelines and in the patient’s best interests.

5.7.3 Where there is no benefit in restarting the patient’s heart and breathing
If the patient is terminally ill and death is inevitable within a short period of time, then that person should be allowed to die naturally with full comfort and palliative measures. The team should:
- Ensure good palliative care is in place to ensure a comfortable and peaceful end for the patient, with support for the significant others,
- Ensure that the patient has and understands as much information about their condition as they want and need (the reasons why CPR will not be offered as a treatment option may be part of this information),
- Document the fact that CPR will not benefit the patient in the medical and nursing notes. (Where the patient does not have Community Nursing Services, documentation would be in the medical notes only),
- Complete the NWAS DNACPR form (appendix 3)

5.7.4 Integrated Care Pathway for the Dying Adult (ICPDA)
The ICPDA provides a localised version of the Liverpool Care Pathway which is being used extensively throughout the UK to support care during the last days and hours of life. The ICPDA provides a comprehensive template of evidence based multidisciplinary care. Within the initial assessment of the ICPDA, clinicians are prompted to consider and document the DNACPR decision for the patient. When starting the ICPDA, the clinical team agree that the patient is dying
naturally, therefore patients who have been commenced on the ICPDA should not be for CPR and this should be clearly documented on the pathway, and in the medical notes.

5.7.5 Where the patient with capacity has asked that CPR NOT be attempted
It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if that refusal may result in death. Where this is the case, the patient’s GP must clarify that the patient fully understands the implications of such a request. The discussion must be fully documented in the medical notes and communicated to all personnel involved in their medical care. Patients who wish to refuse CPR in only certain future circumstances should be encouraged to make a formal ADRT as a DNACPR form would not be appropriate. The making of an ADRT is a voluntary process; people must not be coerced or pressurised into doing this.

5.7.6 Where a patient has a valid ADRT clearly refusing CPR
This should be respected as a legally binding document. If there is any doubt about the validity of an ADRT, Legal Services should be contacted as soon as possible, (for further guidance see appendix 1 and 5).

5.7.7 Where a patient is to undergo a surgical or other invasive procedure (such as cardiac catheterisation, pacemaker insertion)
Under these circumstances, the risk of precipitating an arrhythmia is increased, but the arrest is much more likely to be quickly and readily reversible. It may be appropriate to suspend a DNACPR decision for the duration of the procedure and monitored recovery. Under these circumstances the following steps should be taken:

- Such a decision must be reviewed before the procedure with the patient or their appointed representative if they lack capacity, as part of best interest decision making,
- If a patient requests that an ADRT refusing CPR should include and remain valid during a clinical procedure that is known to significantly increase the risks of cardiopulmonary arrest, and the clinician believes that it would not be safe or successful with the DNACPR decision in place, it may be reasonable not to proceed,
- The agreed DNACPR management option must be documented and communicated to all the healthcare staff managing the patient during the procedure and recovery.

6.0 Who takes responsibility for the decision?
6.1 The overall clinical responsibility for decisions about CPR when a patient is being cared for in the community, including DNACPR decisions, rests with the GP in charge of the patient’s care or ‘usual’ GP. The initial decision not to provide CPR should be made by the GP in charge of the patient’s care, (which in community is the patient’s own GP). It would be considered best practice
to include wider consultation with qualified nursing staff and other members of the multidisciplinary team involved in the patient’s care when making DNACPR decisions.

6.2 When a decision needs to be made urgently, for example out of hours, this should be by the GP who is available at this time. This decision however would need to be reviewed by the patient’s own GP within 5 working days.

6.3 Decisions should be made after discussion with the patient unless they do not wish to talk about it, lack mental capacity or have a valid ADRT. The Resuscitation Council (UK) Patient Information Leaflet (appendix 6) can be used and given to the patient with capacity at the time of the discussion. The patient’s wishes must be taken into account when making a decision. It is not appropriate to discuss resuscitation decisions with a patient who is dying unless they want to have this conversation.

6.4 If the patient has difficulty understanding or communicating decisions, due to sensory impairment, physical disability, lack of understanding of English or other reason, then all reasonable effort should be made to assist them in all relevant discussions.

6.5 At the time of the DNACPR discussion with the patient ensure any record of the assessment of capacity is also documented in the medical and nursing notes.

6.6 If the patient lacks capacity, a DNACPR decision should normally be discussed with the relatives and significant others, unless such discussion has previously been refused by the patient when they had capacity. However relatives and significant others cannot give or withhold consent for the DNACPR decision.

6.7 Occasionally discussion with the patient and/or family members may not be appropriate, and in these cases the doctor should use his/her discretion. An example would be a patient who is dying at the end of a terminal illness. An explanation for not involving the patient or relatives in the decision-making process should be documented on the DNACPR form – e.g.: patient lacks capacity and relatives not available.

6.8 Where DNACPR decisions are not recorded and communicated for patients expected to die and for whom resuscitation would not be successful, First Responders from North West Ambulance Service are obliged to initiate a resuscitation attempt in accordance with their professional and legal obligation.
7.0 Documentation and Communication

7.1 The NWAS DNACPR form is printed on a single sheet as shown in appendix 3. The form must be completed in full, in black ink, legibly with no abbreviations. It must be signed and dated with the doctor’s name, signature and GMC number. A reason for the DNACPR decision must be given. The ‘Review’ section of the form must be completed. Guidelines for completing the form are given in appendix 2. In the event of the patient leaving the home it may be advisable that the form accompanies them.

7.2 Patient-held Document

The DNACPR form needs to remain with the patient in a safe and easily accessible place in the home. The GP recording the decision should inform the other community services involved in the care of this patient and advise that the form is secured into the front of the patient’s hand held records stored within their usual place of residence. Confirmation of the DNACPR should be documented in the medical and nursing case notes. If applicable all documentation pertaining to the DNACPR decision should state clearly what was discussed and agreed with the patient or the health proxy.

7.3 Notifying NWAS

NWAS should be notified within 24 hours of the decision being made, using the NWAS Notification form in appendix 4, either by secure email to nwasnt.eolcmm@nhs.net or secure fax to 0151 261 2666.

7.4 Notifying Other Services

It is the responsibility of the GP who made the decision to ensure the DNACPR decision is communicated to the Community Services caring for the patient within 24 hours of the decision being made, either by secure email or secure fax, or telephone, and to ensure this information has been received and documented accordingly. When Community Services receive notification of a DNACPR decision for a patient who is under their care they are responsible for clearly documenting and communicating this decision in a way that ensures all team members are aware of the patient’s DNACPR status including any review of this status.

7.5 Care Home Residents

Where the DNACPR decision has been made for a care home resident, the NWAS DNACPR form or the Allow Natural Death (AND) form can be used to act as a flag for a DNACPR decision. These two forms are recognised by NWAS and part of the protocol for DNACPR decision-making within East and Central Cheshire. In the event of a care home organisation not using either one of the two specific forms NWAS cannot be held responsible and clinical decision-making in the best interests of the patient may be compromised. Care home
organisations are individually responsible for ensuring their staff are trained in principles of DNACPR, and that the care home organisation adopts local policy to support the standardisation and best practice of DNACPR decisions.

8.0 Validation and Review of a DNACPR decision
The frequency of review is the clinical decision of the GP. If the death is expected and resuscitation attempts would be futile, the default position would be to document ‘Indefinite’. Review is indicated if there is any significant change in the patient’s condition or if medical responsibility for the patient changes (e.g. patient is transferred to another GP Practice or Care Home). In line with best practice it is regarded as necessary to consider the decision every twelve months.

8.1 If a patient with a valid DNACPR decision is transferred to a Care Home, the DNACPR decision still stands. In cases where the GP changes with the change of care setting, the new GP becomes responsible for the patient’s care. Therefore the DNACPR decision by the new responsible GP would need to be completed within 5 working days of the transfer occurring.

8.2 The review date of a DNACPR decision should be carefully considered, as this also has serious implications for keeping other services informed. Whenever the decision is reviewed this must be communicated to other services within 24 hours of the review. If a specific review date is given, in order to remain valid the DNACPR decision must be within the date indicated on the form. If the review date is passed and therefore no longer valid, healthcare professionals would be obliged to carry out CPR.

8.3 Whenever the decision is reviewed and the instruction is upheld, this must be recorded on the DNACPR form by the relevant GP, and include name, signature, date & GMC number. It is not usually necessary to discuss DNACPR decision with the patient each time the decision is reviewed. However, where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it where appropriate. The details of the decision and discussion should be recorded in the medical record at the patient’s GP Practice and communicated to all who need to know within 24 hours, e.g.: North West Ambulance Service (see appendix 4 NWAS Notification form), Community Services, Macmillan, Out of Hours Nursing and GP services.

8.4 If the decision is cancelled, the DNACPR form should be crossed through with 2 diagonal lines in black ballpoint ink and ‘CANCELLED’ written clearly between them. The date, name and signature of the GP cancelling the DNACPR decision must also be clearly
documented. The form should then be removed from the front of the patient's medical records and filed chronologically with the appropriate medical notes. **It is vital that all services involved are informed of the cancellation of this DNACPR decision within 24 hours.**

9.0 **Other Considerations**

9.1 In the event of a cardiopulmonary arrest, if the NWAS First Responders are unsure of the patient’s resuscitation status then a resuscitation attempt should be commenced until clarification is obtained. This affirms the necessity to inform NWAS and provide easy access to the patient held DNACPR form.

9.2 This policy is under regular review and amendments may be required according to audit findings.

10.0 **Planning and Implementation of this Policy**

10.1 This policy requires approval by the Community and Primary Care DNACPR Sub-Committee.

10.2 Once approved the policy will be ratified by the ECT Resuscitation Committee, the Community Safety and Quality Standards Committee, the East Cheshire NHS Trust Risk Management Group and the Clinical Commissioning Board.

10.3 All GPs and Community Services within the three CCGs will be sent a copy of this policy, and it must be ensured that all relevant staff have access to the policy and are appropriately trained in its implementation.

11.0 **Compliance Monitoring**

Please see appendix 9 for Compliance Monitoring toolkit.

12.0 **DNACPR Policy Review**

This interim policy should be reviewed at intervals no longer than three years by the Community and Primary Care DNACPR Sub-Committee.

13.0 **Dignity, Equality and Diversity**

There are no areas in the policy that contravene equality and diversity guidance.
References


## Appendix 1: Advance Decisions to Refuse Treatment

**Factsheet 3: NEoLCP Guide for Health and Social Care Professionals (September 2008)**

(www.endoflifecareforadults.nhs.uk/assets/downloads/factsheet003.pdf)

Always assume the person has capacity to consent to or refuse treatment. You are required to maximise the person’s capacity and facilitate communication

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Does the person have capacity to give consent to or refuse treatment him or herself, with appropriate support where necessary</td>
</tr>
</tbody>
</table>

### IS THE ADVANCE DECISION VALID?

| 2 | Has the person withdrawn the advance decision? (This can be done verbally or in writing) | YES: This is not a valid advance decision. Make sure that you have identified and recorded the evidence that the person withdrew the advance decision<br>NO: Continue with check list |
| 3 | Since making the advance decision, has the person created a Lasting Power of Attorney (LPA) giving anybody else the authority to refuse or consent to the treatment in question? | YES: This is not a valid advance decision. The donee(s) of the LPA must give consent to or refuse the treatment. The LPA decision must be in the person’s best interests.<br>NO: Continue with the checklist |
| 4 | Are there reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making the advance decision and which would have affected his/her decision had s/he anticipated them? | YES: If such reasonable grounds exist, this will not be an applicable advance decision. It is important to identify the grounds, discuss this with anybody close to the person, and identify why they would have affected his/her decision had s/he anticipated them and record your reasoning.<br>NO: Continue with the checklist |
| 5 | Has the person done anything that is clearly inconsistent with the advance decision remaining his/her fixed decision? | YES: This is not a valid advance decision. It is important to identify what the person has done, discuss this with anybody close to the person, explain why this is inconsistent with the advance decision remaining his/her fixed decision and record your reasons.<br>NO: The advance decision is valid. Continue with the checklist |

### IS THE ADVANCE DECISION APPLICABLE?

<p>| 6 | (a) Does the advance decision specify which treatment the person wishes to refuse?*&lt;br&gt;(b) Is the treatment in question that specified in the advance decision? | YES: to both (a) and (b) Continue with the checklist&lt;br&gt;NO: This is not an applicable advance decision |</p>
<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER YES/NO</th>
</tr>
</thead>
</table>
| 7        | **YES:** Continue with the checklist  
**NO:** This is not an applicable advance decision |

**LIFE SUSTAINING TREATMENT**

| 8        | **YES:** continue with the check list  
**NO:** This is not a binding advance decision to refuse the specified life sustaining treatment |
| 9        | **YES:** continue with the check list  
**NO:** This is a binding advance decision to refuse the specified non-life sustaining treatment. It must be respected and followed. |
| 10       | **YES:** continue with the check list  
**NO:** This is not a binding advance decision to refuse the specified life sustaining treatment |
| 11       | **YES TO ALL:** This is a binding advance decision to refuse the specified life-sustaining treatment. It must be respected and followed.  
**NO TO ANY:** This is not a binding advance decision to refuse the specified life-sustaining treatment |

Website  www.endoflifecareforadults.nhs.uk/eolc/acpadrt.htm

Contact details: National End of Life Care Programme  
Email: information@eolc.nhs.uk

Associated links / documents:

- ADRT Training website  [www.adrtnhs.co.uk](http://www.adrtnhs.co.uk)
- Mental Capacity Act  [www.publicguardian.gov.uk/mca/mca.htm](http://www.publicguardian.gov.uk/mca/mca.htm)
- Court of Protection  [www.publicguardian.co.uk/about/court-or-protection](http://www.publicguardian.co.uk/about/court-or-protection)
### DNACPR Decision Making, Documentation and Communication Process

#### DNACPR Decision Making, Best Interests & Capacity

DNACPR decision made, following discussions with patient and family wherever appropriate. The Patient Information leaflet can be used to guide and support discussions [http://www.resus.org.uk/pages/deccprmd.htm](http://www.resus.org.uk/pages/deccprmd.htm)

In the case of a patient who lacks capacity the decision must be made in their ‘Best Interests’. This must be indicated on the DNACPR form. Further supporting information must be written in the patient’s medical notes including the assessment of mental capacity.

If the DNACPR decision is made in the ‘Best Interests’ of the patient, the clinician is legally obliged to take into consideration any previous wishes of the patient prior to them losing capacity. This information may be contained in for example, a Preferred Priorities for Care (PPC), a valid Advance Decision to Refuse Treatment (ADRT), or other advance statement of wishes or care plan.

If the person lacks capacity and has no family to consult then if there is any doubt about whether the decision not to resuscitate is the right decision, an Independent Mental Capacity Advocate (IMCA) must be consulted. See [http://www.ageuk.org.uk/cheshire/Our-services/Advocacy/] for guidance on obtaining an IMCA in Cheshire.

#### DNACPR Form

<table>
<thead>
<tr>
<th>NWAS DNACPR form</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sections should be completed legibly, in black ink, with no abbreviations.</td>
</tr>
<tr>
<td>Patient’s full name, date of birth and address should be written clearly.</td>
</tr>
<tr>
<td>Reason for DNACPR decision, and date should be entered.</td>
</tr>
<tr>
<td>Doctor's name, Signature and GMC number must be clearly printed.</td>
</tr>
</tbody>
</table>

#### Patient-Held Record

Nwas DNACPR form needs to remain with the patient in a safe but easily accessible place in the home. In the event of the patient leaving the home it may be advisable a copy of the form accompanies them.

#### Documentation

The GP recording the decision is responsible for documenting the DNACPR decision in the medical notes.

If applicable all documentation pertaining to the DNACPR decision should state clearly what was discussed and agreed with the patient, or if applicable a Lasting Power of Attorney for Health and Welfare (LPA H&W).

#### Change of Care Setting

If a patient with a valid DNACPR decision is transferred to a Care Home as long as the GP remains the same the DNACPR decision still stands. In cases where the GP changes, the new GP becomes responsible for the patient’s care and therefore their DNACPR decision.

#### NOTE to Care Homes

Where Care Homes are asked by the GP to notify NWAS this must be done securely, ideally by emailing the notification form (appendix 4) to nwasnt.EOLCCMM@nhs.net alternatively faxed securely to 0151-261-2666, using a fax header sheet & taking care to use the correct number to avoid faxes being received by an incorrect recipient.

Nwas cannot take responsibility for miss-sent faxes, and for this reason prefer to receive notification via email using the notification form in line with information governance standards.
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.

The GP recording the decision is responsible for informing other services involved in the patient’s care, **within 24 hours of the decision being made**, and ensuring this information has been received and documented accordingly.

**North West Ambulance Service should be emailed securely using the notification form** *(appendix 4)* nwasnt.EOLCCMM@nhs.net alternatively faxed securely to 0151-261-2666 using a fax header sheet & taking care to use the correct number to avoid faxes being received by an incorrect recipient.

**Other services should be informed where relevant:**

Eg: Community Nursing, Macmillan Nurses, Out of Hours nursing and GP services, Care Homes.

**All Services receiving notification of a DNACPR decision for a patient under their care are responsible for clearly documenting and communicating this decision in a way that ensures all team members are aware.**

If the person with a DNACPR decision dies, the bottom section of the form should be completed NWAS notified using the contact details detailed on the DNACPR form.

### REVIEW OF DNACPR

The frequency of review is the clinical decision of the GP. If the death is expected and resuscitation attempts would be futile, the default position would be to document ‘**Indefinite**’. A DNACPR decision should be kept under review - particularly if there is a change in the clinical state of the patient, or if a review is requested by the patient or those close to them, or any member of the healthcare team.

In line with best practice it is regarded as necessary to consider the decision every twelve months.

The review date of a DNACPR decision should be carefully considered, as this also has serious implications for keeping other services informed. Where the decision has changed, this must be communicated to other services within 24 hours of the review.

If a specific review date is given, in order to remain valid the DNACPR decision must be within the date indicated on the form. If the review date is passed and therefore no longer valid, healthcare professionals would be obliged to carry out CPR.

### CANCELLATION of DNACPR

If the decision is cancelled the DNACPR form should be crossed through with **2 diagonal lines in black ballpoint ink** and ‘**CANCELLED**’ written clearly between them. The date, name and signature of the GP cancelling the DNACPR decision must also be clearly documented. The form should then be removed from the front of the patient’s medical records and filed chronologically with the medical notes.

It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all services involved within **24 hours**.
**Appendix 3:**

**DO NOT ATTEMPT CARDIO PULMONARY RESUSCITATION (DNACPR) DECISION**

To be kept in the front of the patient’s held records in a prominent place in the home.

In the event of respiratory or cardiac arrest, no active resuscitation will be instigated. All other appropriate care and treatment will be provided. Please complete this form using BLOCK CAPITALS. Only to be used for adults (≥18 years) 

This form is to be completed by the patient’s GP or Consultant

---

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Postcode</td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>GP/Consultant Name:</td>
<td>GP/Consultant Telephone</td>
</tr>
<tr>
<td>GP/Consultant Address</td>
<td></td>
</tr>
</tbody>
</table>

Reason for DNACPR (Diagnosis):

---

**CARE PLANNING**

Please select the following interventions/comfort measures required:

- Oxygen Therapy
- Basic Airway Management
- Suction
- Other (please state)

Patient has Preferred Place for Care (PPC) that is:

- Home
- Not Home (please specify)
- Care Home (please specify)

If the patient does not require hospital attendance then please refer to the following:

- District Nurses
- GP

Telephone Numbers are available in patient’s notes

- Other (please state)

---

**RELATIVES**

Has the DNACPR decision been discussed with the patient’s relatives or next of kin?

<table>
<thead>
<tr>
<th>Please tick</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Date of discussion:

Has the DNACPR decision been discussed with the patient?

<table>
<thead>
<tr>
<th>Please tick</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Date of discussion:

If yes to the above, please state with whom it has been discussed with:

If not discussed with patient, please state the reasons:

- Comatose
- Lacks capacity

Has the patient consented to share their information with North West Ambulance Service and Out of Hours (OOH):

<table>
<thead>
<tr>
<th>Please tick</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

GP/Consultant Name:  
GMC No.

GP/Consultant Signature:  
Date:

---

**DNACPR REVIEW**

This decision will be regarded as ‘Indefinite’ unless a review date is specified.

Review period:

<table>
<thead>
<tr>
<th>Specific date (if appropriate)</th>
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</thead>
<tbody>
<tr>
<td>_____ / _____ / ______</td>
</tr>
</tbody>
</table>

Date reviewed

Name & Designation of Reviewer:

Signature:

---

**CANCELLATION OF DNACPR DECISION**

If the DNACPR decision is cancelled the form should be crossed through with two diagonal lines and the work ‘CANCELLED’ written clearly between them. The section below completed by the patient’s GP/Consultant. In the event of the patient dying the nurse may complete this section.

<table>
<thead>
<tr>
<th>GP/Consultant/Nurse Name:</th>
<th>Cancellation Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GP/Consultant/Nurse Signature:

Reason for Cancellation:

Once completed please email securely via NHS net to (Cheshire & Merseyside) nwasnt.eolcmm@nhs.net / (Greater Manchester) nwasnt.eolcmm@nhs.net or Fax securely to:0151-261-2666
**END OF LIFE CARE ALERT NOTIFICATION FORM**

Please complete this form using BLOCK CAPITALS. *This form is to be completed by the Patient’s GP, Consultant or Lead Clinician*

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>D.O.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Postcode</td>
</tr>
<tr>
<td>NHS Number</td>
<td>Patient’s Tel. No.</td>
</tr>
<tr>
<td>GP Name:</td>
<td>GP Address</td>
</tr>
</tbody>
</table>

**Has the patient consented for the sharing of their information with NWAS or Out of Hours:**

- ☐ Yes
- ☐ No

Please select from the following instructions to report them as currently active:

**IMPORTANT:** Please ensure patient has documentation with them at address. *i.e. DNACPR*

- ☐ Advance Decision to Refuse Treatment (ADRT):
- ☐ Liverpool Care Pathway / Integrated Care Pathway:
- ☐ Allow Natural Death (AND):
- ☐ Preferred Priorities for Care (PPC):
- ☐ Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR):
- ☐ Statement of Intent

Please select the duration for the flag to be held on the system

- ☐ One Month (30 Days)
- ☐ Two Months (60 Days)
- ☐ Three Months (90 Days)

Please indicate where you believe the patient currently is on the North West Model for EoLC (End of Life Care):

- ☐ Advancing Disease 1 year +
- ☐ Increasing Decline 6 Months
- ☐ Last Days of Life

Any message in a bottle/property access/location of care plan directions:

*Note: when a warning flag is due to expire for the patient, an email will be sent to the email address provided below. To maintain the flag on the patients address, you will be required to update the information and forward it to NWAS as soon as possible.*

Contact details for any queries regarding this flag can be directed to the following:

<table>
<thead>
<tr>
<th>Telephone No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>(Confirm Email)</td>
</tr>
</tbody>
</table>

Please also note that you are required to update the record if the patient dies or there is a change in circumstances such as change of Address. Contact NWAS with the change of details

Once completed please email securely via NHS net to (Cheshire & Merseyside) nwasnt.eolcmm@nhs.net / (Greater Manchester) nwasnt.eolcmm@nhs.net or Fax securely to: 0151-261-2666

- An advance decision enables someone aged 18 and over, while still has capacity, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

- Provided that an Advance Decision to Refuse Treatment is valid and applicable to current circumstances, it has the same effect as a decision made by a person with capacity: healthcare professionals must follow the decision.

- Healthcare professionals will be protected from liability if they:
  - Stop or withhold treatment because they have seen and read an advance decision (to refuse treatment), and that it is valid and applicable
  - Treat a person because, having taken all practical and appropriate steps to find out if the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.

- People can only make an advance decision under the Act if they are 18 or over and have the capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time.

- 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”.

- To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:
  - Has done anything that clearly goes against their advance decision
  - Has withdrawn their decision
  - Has subsequently conferred the power to make that decision on an attorney, or
  - Would have changed their decision if they had known more about the current circumstances

- Sometimes healthcare professionals will conclude that an advance decision does not exist, is not valid and/or applicable – but that it is an expression of the person’s wishes. The healthcare professional must then consider what is set out in the advance decision as an expression of previous wishes when working out the person’s best interests

- Some healthcare professionals may disagree in principle with patients’ decisions to refuse life-sustaining treatment. They do not have to act against their beliefs. But they must not simply abandon patients or act in a way that affects their care.

- Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983.
Appendix 7: Equality Analysis (Impact assessment)

What is being assessed? Name of the policy, procedure, proposal, strategy or service:

Interim Do Not Attempt Cardio-Pulmonary Resuscitation Policy for Clinical Commissioning Group and Community Services during NWAS pilot period

Details of person responsible for completing the assessment:

- Name: Jane Colling
- Job title: End of Life Care Lead Facilitator
- Team: End of Life Care

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

The overall aim of this interim DNACPR policy is to support community professionals who are actively engaged in the care of patients known to be in the last months of their life. This document will be circulated to all GPs and Community Nursing Teams within the Eats and Central Cheshire Clinical Commissioning groups, and will provide guidance to those healthcare professionals who are:

- involved in considering and documenting the DNACPR decision of patients,
- caring for patients with a DNACPR decision,
- supporting patients who have an ADRT that includes refusing CPR,
- caring for patients at the end of life,
- involved in communicating DNACPR decisions across the multi-professional team.

In conjunction with the General Medical Council (GMC) a joint statement by the British Medical Association (BMA), the Royal College of Nursing and the Resuscitation Council (UK) was issued in October 2007. New recommended standards for recording DNACPR were issued in 2009 by the Resuscitation Council. These guidelines have been used to prepare this document. This policy represents the individual’s absolute right to life in accordance with the Human Rights Act (1998) and the Mental Capacity Act (2005).

2. CONSIDERATION OF DATA AND RESEARCH

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

The policy will support and inform the practice of all East Cheshire Community Business unit staff who are caring for patients with a DNACPR decision.

Age:
17.8% (30,500) of the population in Cheshire East is over 65 compared with 15.9% nationally. This results in a high “old age” dependency ratio, i.e. low numbers of working-age people supporting a high non-working dependant older population. The percentage of “older” or “frail” old is also considerably higher, with 2.3% (8,200) persons 85 and over compared to 2.1% nationally.

Cheshire East has the fastest growing older population in the North West. By 2016, the population aged 65+ will increase by 29.0% (8,845) and the population aged 85+ by 41.5% (3,403).

This will have an impact on the number of patients being managed by ECT and the complexity of the health and social care issues that the older person is experiencing. In addition the staffing profile of ECT will change to include an increasing number of staff over 65 in the workforce.

Race (data from ‘Cohesia’ (local diversity report 2005))
94.6% is White British & 5.42% is made up of BME people (black and minority ethnic)
Non-white ethnic minorities = 2.8% of the population

Issues for BME communities - lack knowledge of services, access to services, access to translation/interpretation, cultural differences, family values. Many people from BME communities experience poverty, poor housing and unemployment which make it difficult for them to lead healthier lives.

Gypsies and travellers – higher number in Borough of Congleton – specific issue is higher percentage of this group reporting long term illness – 42% compared to 18% of settled population; average life expectancy 10-12 years less than settled population; 18% of gypsy and traveller mothers have experienced the death of a child compared to 1% in the settled population.

Disability:
There are over 10 million disabled people in Britain, of whom 5 million are over state pension age. Nearly one in five people of working age (7 million, or 18.6%) in Great Britain have a disability.
Hearing loss: One in 4 has a hearing problem.
Sight problems: There are two million people with sight problems in the UK.

Learning disabilities: There is quite a high proportion of people with learning disabilities in the local area due to there being a number of residential homes/institutions in the area. Problems encountered can be lack of staff awareness, communication issues, information requirements.

Dementia
Approximately six in 100 people aged over 65 develop dementia and this rises to around 20 in 100 people aged 85 or over. Dementia affects 750,000 people in the UK.

Carers
Around 6 million people (11 per cent of the population aged 5+) provided unpaid care in the UK in April 2001. While 45 per cent of carers were aged between 45 and 64, a number of the very young and very old also provided care. By 2037, it’s anticipated that the number of carers will increase to 9 million.

Gender
In Cheshire East, 49% are male and 51% are female

Transgender:
No local date available, national trends show:
1/12,000 males, transgender from male to female
1/33,000 females, transgender from female to male
Specific issues around access to services, specific services for men or women, and ‘single sex’ facilities

In terms of the transgender population, GIRES (Gender Identity Research and Education Society)
gives an estimate of 600 per 100,000. If these figures were applied to the Cheshire East community, there may be around 1,790 trans people in the area.

**Religion/Belief**

In the Cheshire East area the 2001 census showed:

- Christian: 80%
- Buddhists: 0.16%
- Hindu: 0.15%
- Jewish: 0.12%
- Muslim: 0.36%
- Sikh: 0.05%
- Other religion: 0.15%
- No religion: 11.84%
- Not stated: 6.67%

The Muslim population has the highest levels of ill health amongst faith groups – this includes higher smoking rates amongst men and higher rates of coronary heart disease and diabetes.

**Sexual Orientation**

Lesbians, gay men and bi sexual people (LGB) make up to 5-7% of the UK population (Dept of Trade and Industry, 2003). 13% of Gay men and 31% Lesbian women are parents (Morgan and Bell, First Out: Report of the findings of Beyond the Barriers national survey of LGB people).

The experience and health needs of gay men and women will differ. However, both groups are likely to experience discrimination, higher levels of mental ill health and barriers to accessing health care.

National Health Inequalities data shows that lesbian, gay, bisexual and transgender (LGBT) people are significantly more likely to smoke, to have higher levels of alcohol use and to have used a range of recreational drugs than heterosexual people. They are also at greater risk of deliberate self-harm. Although most LGBT people do not experience poor mental health, research suggests that some are at higher risk of mental health disorder, suicidal behaviour and substance misuse.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

None

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. ASSESSMENT OF IMPACT

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, racial groups differently?  
Yes √  No □

**Explain your response:** The service may well look after patients from different race, and they may not be familiar with their needs. Action needed to ensure all staff know how to access interpretation/translation facilities. Action also needed is to make sure all staff know where to find information to enable them to adhere to cultural requirements of different faiths, eg post death procedures policy, booklet on privacy, dignity, religious and cultural needs. Ensure staff aware to check content of drugs eg porcine products not suitable for Muslim patients.

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, different gender groups differently?  
Yes √  No □

**Explain your response:** Staff may not be familiar with dealing with transgender patients – ensure all are aware of transgender policy.

**DISABILITY**
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, disabled people differently?  
Yes √  No □

**Explain your response:** Looking at the statistics, it is clear to see that many of the local population have hearing loss or visual impairment. There are also many with learning disabilities. Staff need to be aware of the need for good communication and the need to provide information in other formats, including easy read or to access BSL interpretation.

There is a variety of training on offer in the trust and staff need to access this, ie equality, hearing loss, dementia, learning disabilities

**AGE:**
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, age groups differently?  
Yes □  No √

**Explain your response:**

**LESBIAN, GAY, BISEXUAL:**
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  
Yes □  No √

**Explain your response:**

**RELIGION/BELIEF:**
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?  
Yes √  No □

**Explain your response:** See section on race.

**CARERS:**
From the evidence available does the **政策, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently?  
Yes √  No □

**Explain your response:**  □ It is important to inform and involve carers in the care of their loved one and offer them access to support and information.
OTHER: EG Pregnant women, people in civil partnerships, human rights issues. From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☑ No ☐

Explain your response: People in civil partnerships have the right to have their nearest and dearest involved in their care if they so wish and to be treated as a member of the family.

4. Safeguarding Assessment - CHILDREN

a. Is there a direct or indirect impact upon children? Yes ☐ No ☑

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

c. If no please describe why there is considered to be no impact / significant impact on children

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

GPs and Clinical Commissioning Group leads, community nursing staff and managers East Cheshire Trust Resuscitation Committee

6. APPROVAL – At this point, you should forward the template to:

- The Trust’s Equality and Diversity Lead lynbailey@nhs.net
- The Named Nurse for Safeguarding Children melaniebarker@nhs.net

Equality and Diversity response: 
Safeguarding Children response:

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

8. Review Date: December 2013

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
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<tbody>
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Date completed: December 2011

The Trust’s Equality and Diversity Lead: 

The Named Nurse for Safeguarding Children:..........................
Appendix 8: Brief Communication Strategies when opening a DNACPR conversation
The incorporation of advance care planning into end of life care means that we are all facing
the challenge of having difficult conversations with patients about issues such as Do not
attempt resuscitation, and patient preferences at end of life. The following guidance may
help to open discussions, lead to open and honest conversations, and result in greater
likelihood of achieving the patient’s wishes and guiding sound clinical practice.

If you find opening discussions about end of life difficult, the following conversation
openers might help:
"What are your thoughts about the future? How do you see things going?"
"In thinking about the future, have you thought about where you would prefer to be cared for
as your illness gets worse?"
"What do you see happening with your illness over the next few months?"
"It would be good to discuss what kind of medical care you would want if you should get sick
again. How do you feel about talking about this?"

Introducing a conversation about resuscitation may lead on from discussions about
prognosis and the patient going on your GP Palliative Care register, or discussing the
patient’s understanding of the course of their illness. It may however require the
professional to ask open direct questions in order to raise the issue specifically.
“You said you haven’t been feeling as well the last few weeks, what is your understanding of
what is happening?”

Within the conversation look for cues from the patient, on which you can pick up to
steer the conversation in the direction you need it to go.
“You said earlier that you feel things are getting worse, shall we talk more about that?”
“You said you are anxious about the future, would it help to discuss what kind of things can
be put into place to make sure your choices are upheld?”

Where cues are given, pick up on them specifically and use them to take the
conversation forward:
“You said you are finding things very hard, is it ok if I ask you more about that?”
“You said you don’t want to go back into hospital, would it help to write down your priorities
in an advance care plan?”

Patient’s who don’t give specific cues:
Within your consultation ask the patient specifically about their view of the future, eg:
“In thinking about the future, have you thought about where you would prefer to be cared for
as your illness gets worse?”
“It would be good to discuss what kind of medical care you would want if you should get sick
again. How do you feel about talking about this?”

When you need to raise the subject specifically:
“It is important that we put things in place to keep you safe, I wonder if I could talk to you
about that?”
“Can we discuss the important issue of resuscitation?” If they respond with “No”, you would
need to follow-up with another direct “It is important that we make sure things are in place to
help you and those looking after you”
When talking about patient priorities for future care, use the skills of empathy and acknowledgement explicitly, eg:

“You are obviously concerned about how things may go in the future? What would help you to feel more confident about the future?”
“You said your health worries you, what is it that is most worrying?”
“You don’t think your husband would be able to manage, although you would like to stay at home? That must be hard for you?”

Use clarification to check their understanding:

“Can you explain to me what you understand about your condition?”
“Can you tell me what you feel may happen in the future?”

“If you do not ask your patients to record their preferences for care and death, then you are not leaving this choice up to your patient, instead potentially leaving their fate to chance.”

Many of us find it difficult to initiate advance care planning discussions, however, once established as integral to best practice in end of life care, the benefits outweigh the initial hesitation. The following case studies may provide helpful guidance. [www.dyingmatters.org](http://www.dyingmatters.org)

1. By Dr P Nightingale, GP in Lancaster

Ron Smith (not real name) was a well known patient to me. He was an 82-year-old retired teacher with diabetes, peripheral neuropathy and ischaemic heart disease. He developed heart failure and was admitted to hospital after a convulsion caused by hyponatraemia. He saw me 4 months ago requesting no further hospital admissions and expressing a desire not to be resuscitated.

We discussed future planning and he agreed to look at advance care planning documentation.

He was content to complete a preferred priorities of care (PPC) document and a Do Not Attempt Resuscitation (DNACPR) form. He took these documents away, discussed them with his family and brought them back to me a week later. I notified the out of hours GPs and the local ambulance service and all my partners. We added him to our practice palliative care register.

A dignified death

Four months later, Ron started to decline. He was offered acute admission but he requested to stay at home. One morning, having eaten breakfast with his wife, Ron suddenly collapsed, as is common in chronic heart failure. He died in his home and the last words he heard were those of his loving wife.

Without advance care planning, Ron could so easily have had a hospital death, with a futile and undignified attempt at resuscitation. After Ron's death I sat with his wife in the lounge. Ron's PPC was on the coffee table. We flicked through it and realised that Ron had achieved the death he had wished for months before. This was of great comfort to his wife and professionally satisfying for me. Without advanced care planning, the bereavement experience of this family would have been very different.
2. By Professor Mayur Lakhani, GP & appraiser, Leicestershire, Chair of Dying Matters

He talks about an elderly patient who wanted to die at home, and the measures he put in place to help ensure the patient had his wishes met.

Last year, I saw an 80-year-old man, for acute exacerbation of COPD. He was accompanied by his family, who expressed concern that he was becoming frail. His wife, who was also his carer, reported that he had developed faecal incontinence. He had complex co-morbidities.

The basis for putting him on the EOLC register was as follows: my answer to the 'Surprise question' was 'No'. He had progressive life-limiting illnesses; spent the majority of his time chair or bed-bound, needing more care; he had multiple medical conditions - short of breath at rest, low BMI; two recent unplanned admissions; worsening dementia and faecal incontinence.

What happened next

I initiated discussion (week 1) and arranged a meeting with his family (week 2), followed by a home visit (week 3). I simultaneously referred the patient to the community matron. Preferred Priorities for Care (PCC), which stated the patient wanted to be cared for at home. A Do Not Resuscitate order was signed, as was the Out of Hours and Ambulance Service.

What difference did this make?

The patient and his family welcomed having an open discussion and were relieved that the subject had been raised. Putting the patient on the register and creating a plan of care transformed the situation, giving both the patient and the family a great sense of relief. The patient's quality of life improved, and support for his wife, who was his primary carer, also improved through Marie Curie nurses.

After my first consultation with the patient, he had two out of hours contacts but no hospital admissions. He died, in his own home, in May of the following year surrounded by his family.
## Appendix 9: Compliance Monitoring Tool

<table>
<thead>
<tr>
<th>Policy</th>
<th>COMMUNITY DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION POLICY</th>
</tr>
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<tbody>
<tr>
<td><strong>Author</strong></td>
<td>Jane A Colling</td>
</tr>
<tr>
<td><strong>Date of Approval</strong></td>
<td>12 September 2012</td>
</tr>
<tr>
<td><strong>Date for review</strong></td>
<td>2015</td>
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<tr>
<td><strong>NHSLA Criterion Number (as applicable)</strong></td>
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<td><strong>Approving Committee/Group</strong></td>
<td>SQS &amp; Risk Management Group</td>
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<tr>
<td><strong>Requirement to be monitored</strong></td>
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<tr>
<td><strong>Process to be used for monitoring e.g. audit</strong></td>
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<tr>
<td><strong>Responsible individual/committee for carrying out monitoring</strong></td>
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<tr>
<td><strong>Frequency of monitoring</strong></td>
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<tr>
<td><strong>Responsible individual/committee for reviewing the results</strong></td>
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<tr>
<td><strong>Responsible individual for developing an action plan</strong></td>
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<td><strong>Responsible Committee/group monitoring the action plan</strong></td>
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<tr>
<td><strong>Do Not Attempt Cardiopulmonary Resuscitation Orders (DNACPR)</strong></td>
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<tr>
<td><strong>Audit</strong></td>
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<tr>
<td><strong>Community DNACPR Subcommittee</strong></td>
<td></td>
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<tr>
<td><strong>Once per year</strong></td>
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<tr>
<td><strong>Community DNACPR Subcommittee</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Annamarie Challinor: Macmillan End of Life care Team leader</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Community DNACPR Subcommittee</strong></td>
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Appendix 10: Decision making Framework

Is cardiac or respiratory arrest a clear possibility for this person?

If there is no reason to believe that the individual is likely to have a cardiac or respiratory arrest it is not necessary to initiate the discussion with them (or those close to the person who lacks capacity) about CPR. If however the individual wishes to discuss CPR this should be respected.

When a DNACPR decision is made on these clear clinical grounds, it is not appropriate to ask the person’s wishes about CPR, but careful consideration should be given as to whether to inform them of the DNACPR decision.

Where the individual lacks capacity and has Lasting Power of Attorney (Health & Welfare) this person should be informed of the DNACPR decision and the reasons for it as part of the ongoing discussion about the individual’s care. If a second opinion is requested this should be respected whenever possible.

Does the person lack capacity?

Do they have a VALID and APPLICABLE ADRT, if so this must be respected. If an attorney (H&W) has been appointed they should be consulted.

If no, a decision will be made on the basis of BEST INTERESTS. Decision makers have a legal duty to consult with those close to the individual who lacks capacity. 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.

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

When there is only a very small chance of success and there are questions as to whether the burdens outweigh the benefits of attempting CPR, the involvement of the individual (or if the person lacks mental capacity those close to him/her) in making the decision is crucial. When the individual has mental capacity their own view should guide the decision making.

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