Decisions relating to Unified Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)
Why DNACPR?

• The primary goal of healthcare is to benefit patients by restoring or maintaining their health, thereby **maximising benefit** and **minimising harm**.

• If treatment fails or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, then that treatment is no longer justified.  
  (BMA, RC(UK), RCN 2007)
1. To understand the changes which are happening in our area
2. To provide an overview of decision making in DNACPR
3. To explore legal and ethical considerations of DNACPR decisions
4. To outline existing local policy and process in relation to unified DNACPR
5. To explore perceived barriers when making DNACPR decisions
Background
Time for a change

• We are changing from a local DNACPR policy to a regional one

• The regional one will be called the Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Adult Policy

• From August 1\textsuperscript{st}, 2014 we will be fully embracing this policy
What are the differences?

• We currently have different DNACPR forms dependant upon setting i.e the community and care homes form is different to the hospital form
• Community forms are currently not accepted in hospital and vice versa
• The new form and the new policy supporting it will be for ALL care settings. **No separate forms**
• The new form will be easily recognised with its ‘lilac’ colour (we will see an example later)
Why?

NEGATIVE

• Having the ‘wrong’ DNACPR form in wrong setting led to inappropriate decision making

• People inappropriately resuscitated in ambulances due to forms not being recognised

• Distressing circumstances made worse by forms that have not been accepted on transfer

• People being subjected to repeated ‘difficult conversations’ about DNACPR
Why?

POSITIVE

• One form clearly recognisable due to its ‘Lilac’ colour
• Regional initiative across North West
• Led by North West Ambulance Service
• Based upon tested model operational in South Central region
• Reduced need for repeated difficult conversations
• Clear process of audit across care settings
Making a DNACPR Decision
Where does a DNACPR decision sit?

• A DNACPR decision is just ONE decision which sits amongst other decisions concerning Advance Care Planning

• It involves a real person with a real family trying to make decisions which are often painful, but very important
Definitions

- **Cardiac Arrest** –
  Sudden cessation of heartbeat and cardiac function, loss of effective circulation

- **Respiratory arrest** –
  Sudden and complete cessation of breathing

- **Cardio Pulmonary Resuscitation (CPR)** – Emergency procedure relating to external cardiac massage and sometimes artificial respiration

- **DNACPR** –
  Do not attempt cardio pulmonary resuscitation
ALL people are presumed to be for CPR unless:

- A valid DNACPR decision has been made and documented or;

- A valid and applicable Advance Decision to Refuse Treatment (ADRT) prohibits CPR
DNACPR mixed messages

- DNACPR form does **not** mean no active treatment. It **only** means “not for CPR”
- A DNACPR order must not in itself influence other treatment decisions unless directly related
- Clinicians must continue to treat each episode of care - ‘maximising health, minimising harm’
Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully.

Decisions should be reviewed regularly and when circumstances change.

Advice should be sought if there is uncertainty.


Cardio Pulmonary Resuscitation DECISION-MAKING FRAMEWORK

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

- NO

Is there a realistic chance that CPR could be successful?

- NO

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

- NO

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

- NO

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

- YES

Where NO REASON to believe that the patient is likely to have a cardiac/respiratory arrest – it is not necessary to initiate CPR discussion with the patient (or for patient who lacks capacity, those close to patient/welfare attorney)

If patient chooses to do so, this should be respected.

When clinical decision is made NOT TO ATTEMPT RESUSCITATION on these grounds it is not appropriate to ask patient’s wishes.

Careful consideration should be made to whether/how to inform patient (or for patients who lack capacity, those close to patient/welfare attorney) of the decision.

If patient has made an advance decision REFUSING CPR & criteria for applicability & validity are met – this must be respected.

If a welfare attorney or guardian has been appointed, they should be consulted.

When only a small chance of success, and concerns exist whether burdens outweigh benefits of attempting CPR, involvement of patient (or if patient lacks mental capacity, those close to them/welfare attorney) in making the decision is crucial.

When the patient is a child/young person, those with parental responsibility should be involved in the decision where appropriate.
DNACPR decisions;

DNACPR decisions can **ONLY** be made by:
• **HOSPITALS**- FY2 level Doctors and above
• **CARE HOME/COMMUNITY**- GP/GP Registrars

Decisions must:
• Respect the wishes of the individual, where possible
• Reflect the best interests of the individual
• Provide benefits which are not outweighed by burden
Meeting patient needs......(2007 Joint Statement)

Consider.....

Group 1: no reason to believe cardio-respiratory arrest is likely

Group 2: arrest is possible/likely, but CPR would be unsuccessful

Group 3: arrest is possible/likely, & where CPR could be successful
• For the majority of people receiving care in a hospital or community setting, the likelihood of cardiopulmonary arrest is small

• Therefore no discussion of such an event routinely occurs unless raised by the individual
Group 2: arrest is possible/likely but CPR would be unsuccessful

• For irreversible conditions where death is the likely outcome CPR should not be attempted as it would NOT restart the heart and breathing
• The individual (and those important to them) should be informed of this.
• If staff feel that such a discussion would be too difficult for the individual, or if the person is actively dying, a discussion to say they will not be resuscitated is not always needed as it could cause even more distress
• Communicating with the relatives/carers is very important in this instance and is deemed best practice
• Consider in terms of individual and, where applicable, those close to them and information provided
  – based these on understanding of condition, and reason CPR is deemed to be futile
  – but also focus on what will still be done e.g. other active treatment
• Do not assume each person’s information needs - check
• DNACPR written decision must document the fact that “CPR will not succeed due to ...”
Group 3: arrest is possible/likely, & where CPR could be successful

- The individual should be asked whether they would want CPR to be performed- they may wish for their family or friends to be involved in the decision
- Opportunity must be made for timely support and information that help them to consider contextual decisions of consent/refusal
- Clarifying circumstances that are important to the person (e.g. ADRT, alongside DNACPR order refusal of treatment/s when respiratory arrest alone initially occurs)
What if someone lacks capacity?

• Consider any previously expressed wishes
• Share available information with relatives
• Check whether the person has a Lasting Power of Attorney (LPA)
  • Box EXPLICITLY giving LPA permission to refuse life saving treatment must be completed
• Each page of document needs an Office of the Public Guardian stamp
• LPA with this authority only refuse - CANNOT demand CPR is performed
LPA’s for Health & Welfare

**Option A**

I want to give my attorneys authority to give or refuse consent to life-sustaining treatment on my behalf.

Signed in the presence of a witness by the person who is giving this lasting power of attorney

Your signature or mark

Date signed or marked

The date you sign (or mark) here must be the same as the date you sign or mark section 10 Declaration.

Who can be a witness

**Option B**

I do not want to give my attorneys authority to give or refuse consent to life-sustaining treatment on my behalf.

Signed in the presence of a witness by the person who is giving this lasting power of attorney

Your signature or mark

Date signed or marked

The date you sign (or mark) here must be the same as the date you sign or mark section 10 Declaration.

Witnessed by
Independent Mental Capacity Advocates (IMCA)

- Arrange & consult in all cases where there is no close family member/friend to consult
- Lack of availability of IMCA should not preclude making DNACPR decisions that are clearly made upon medical grounds
  - i.e. when not involving weighing up of benefits against burdens
Case studies
Communication
General communication

• Use the **information booklet** to support your communication

• Communication should be done by an **experienced member of the team**, where possible by someone with an established rapport with the individual and their family

• Individuals and/or those close to them have the **right to refuse to take part in the discussions**
General principles - Do’s

• Discussions must be approached sensitively
  – May be concerns that DNACPR decisions are influenced by uninformed/unfounded assumptions about patient’s disability or advanced age on their quality of life

• Start - what you are going to do, not what you’re NOT

• Usually conversation constitutes breaking bad news

• ‘To resuscitate’ may be jargon to some; others may feel the term implies that it could actually work
General Principles – Don’t

• Don’t offer it as an option if there is no chance that it will work
• Don’t make it a relative’s decision – it is not
  – unless an LPA with authority to make health & welfare decisions including life sustaining treatment – *if* patient lacks capacity at the time

“How bad is it doctor? Should I start dating?”
When to discuss DNACPR

• As soon as becomes necessary to reach a decision concerning DNACPR

• When the person is supported
  – i.e. not alone in a hospital bed or house – unless unavoidable or if the conversation is initiated by the person themselves

• When YOU and the individual concerned have time

• If person declines to take part in the discussion, that is OK
  – Record the fact
Saying the right thing

• Need to emphasize what the decision means: treatment for all the reversible things we can, but if it doesn’t work and the heart stops beating then there isn’t anything we could do to restart it
• Wouldn’t preclude hospital treatment (if appropriate)
• Has no bearing on other things such as, for example, receiving chemotherapy
• On admission the lilac form must be brought to the care settings by the individual or those close to them
• The individual or those close to them at home should alert paramedics etc. as to the location of the form
Disagreement?

• NO-ONE can demand a clinically inappropriate treatment
• Sensitive and honest communication will reduce the risk of disagreement
• Use case conferences, mediation etc. if necessary
• Second opinion from a senior medic should be sought
• Consult with legal department
• Patients cannot be forced to keep a DNACPR form in their house if they don’t want one
Documentation
• The legal aspect of making a DNACPR decision lies within the entry you make within medical notes NOT the DNACPR form. This just acts as a ‘flag’

• Always document discussions and decisions

• Decisions should be accessible to all healthcare professionals who may need them

• Decisions relating to CPR should be communicated between healthcare professionals when patients move between settings
  i.e. via EDNF, EMIS Web, OOH communication
New Form

• A fixed review date is not recommended. This decision will be regarded as “INDEFINITE” unless:
  i. A definite review date is specified
  ii. There are changes in the person’s condition
  iii. Their expressed wishes change

• The basis on which the decision has been made and what conversations have occurred about it should be recorded
LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR. WHITE FORMS FOR AUDIT AND NOTES.

ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

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

Name:
Address:
Post code:
Date of birth: / / 
NHS or hospital number: [black]

<table>
<thead>
<tr>
<th>Date of DNACPR Decision</th>
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</thead>
<tbody>
<tr>
<td>/ /</td>
</tr>
<tr>
<td>Institution Name</td>
</tr>
<tr>
<td>Form completed electronically? Yes □ No □</td>
</tr>
<tr>
<td>Before completing this form, please see explanation notes</td>
</tr>
</tbody>
</table>

1. Reason for DNACPR decision: (select A, B or C)

☐ A) CPR is unlikely to be successful due to

This decision has been discussed with the person Yes □ No □ If No state reason
The relevant other has been informed of the decision Yes □ No □ If No state reason
Name of relevant other:

☐ B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person.

• Person involved in discussions? Yes □ No □ If No state reason
• Person lacks mental capacity and has a legally appointed Welfare Attorney: Name
• Person lacks mental capacity and does not have a legally appointed Welfare Attorney. Decision is made on the balance of overall benefit to the person in discussion with: Name(s)

☐ C) There is a valid advance decision to refuse CPR in the following circumstances: All circumstances Yes □ No □
Specific Circumstances (please state):

Attach a copy of the Advance Decision to Refuse Treatment (ADRT) to the back of the DNACPR form.
2. Healthcare professional making this DNACPR decision:
   Name: 
   Position: 
   GMC/NMC: 
   Signature: 
   Date: / / 
   Time: : 
   If decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:
   Name: 
   Position: 
   GMC/NMC: 
   Signature: 
   Date: / / 
   Time: :

3. Review: (Select ONE box only) □ This is an indefinite decision / □ Needs reviewing
   Review date if appropriate: / / 
   Outcome of review: DNACPR to continue? Yes □ No □
   Name: 
   Position: 
   GMC/NMC: 
   Signature: 
   Date: / / 
   Time: :

4. Who has been informed of this DNACPR decision?
   Please Tick
   □ GP
   □ Ambulance Warning Flag
   □ Out of Hours
   □ Care Provider (Please state)
   □ Other (Please state)

5. Other important information:
   For example, ambulance crew instructions on transfer, Ceilings of treatment, Preferred place of care/death, Tissue or Organ donation.

The DNACPR form is located:

Name:
Address:
Post code:
Date of birth: / / 
NHS or hospital number: ___ ___ ___

Important: this form MUST be printed on lilac paper
New Form- Acute Hospitals

- The **triplicate copy** of the form stays within the medical notes until discharge.
- On discharge the **lilac copy** is given to the person (and remains their patient held copy).
- One **white copy with lilac stripe** remains in the medical notes.
- One **white copy** is retained for audit purposes and should be sent to the resuscitation officer at the time of discharge/death.
**Acute Care- Consultant Endorsement**

APPLIES TO uDNACPR DECISIONS INITIATED IN ACUTE CARE ONLY

A Consultant **MUST** sign to verify a uDNACPR decision that has been initiated by a more junior doctor (FY2 and above) **by the end of the next day**.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th>GMC/NMC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date:</td>
<td>Time:</td>
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APPLIES TO uDNACPR DECISIONS INITIATED IN ACUTE CARE ONLY

Once informed of the DNACPR the Registered Nurse **MUST** tick the ‘other’ box in section 4 and then print and sign their name followed by the date and time of notification.
New Form- Community/Care Homes

- The GP must print the electronic uDNACPR form onto ‘lilac’ paper. This should be completed wherever possible at the home or care home.
- ‘The original lilac’ document to remain with the individual and kept at the front of care notes e.g. District Nurse notes or in another identified secure place.
- GP’s need to read code the DNACPR onto electronic patient notes (1R1).
- Inform NWAS via ERISS.
- Community audit process will likely centre around significant event analysis.
Guidance Notes available on the reverse of the form
Using the form

• The lilac form must ALWAYS remain in the person’s possession

• The lilac form travels with the person between care settings

• There should be written documentation within the person’s medical notes to say they have a DNACPR form

• The form can only be accepted if it is the original ‘lilac’ copy, i.e. not a photocopy
**Communication from Secondary Care to the Community**

- **Electronic discharge notification form example:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Name and role of initiating clinician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Order in place for this patient?</td>
<td></td>
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<tr>
<td>If yes, was the uDNACPR first initiated during this admission? (if yes is indicated, this will trigger an internal process that will ensure Out of Hours’ GP’s and North West Ambulance are notified)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the uDNACPR decision indefinite?</td>
<td>Yes</td>
<td>No</td>
<td>Date of discussion:</td>
</tr>
<tr>
<td>Has the uDNACPR decision been discussed with the patient?</td>
<td>Yes</td>
<td>No</td>
<td>Date of discussion:</td>
</tr>
<tr>
<td>If not discussed with the patient, please state the reasons:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the uDNACPR decision been discussed with the patient’s relatives/significant others?</td>
<td>Yes</td>
<td>No</td>
<td>Date of discussion:</td>
</tr>
<tr>
<td>If yes, please state with whom it has been discussed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, please state the reasons:</td>
<td></td>
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</table>

**IMPORTANT: PLEASE ENSURE ‘LILAC FORM’ ACCOMPANIES THE PATIENT HOME**
Communication
From the Community to Secondary Care

This can be facilitated in various ways:

• Person/family member presents the original ‘lilac’ copy of the uDNACPR on arrival to hospital

• NWAS are alerted of the uDNACPR via the GP using ERISS which enables them to handover this information (and the form which they will retrieve from the home) to acute care setting

• The GP letter/ telephone call to inform acute care that the person has a uDNACPR .Prompting acute staff to request to see this on arrival of the person- or to complete a new form if this has not been brought into hospital with the person
Cancelling the decision

• If the decision is cancelled, the form should be crossed through with **two diagonal lines in black ink and the word ‘CANCELLED’** written clearly between them, dated, signed and name & designation printed by the health care staff

• Retain the cancelled form in the person’s notes

• It is the responsibility of the person cancelling the decision to **communicate this to all parties** informed of the original decision
The Decision to cancel should be made by:

HOSPITAL: FY2 & Above
COMMUNITY/CARE HOME: a GP/GP Registrar
Session objectives – did we achieve them?

1. To understand the changes which are happening in our area
2. To provide an overview of decision making in DNACPR
3. To explore legal and ethical considerations of DNACPR decisions
4. To outline existing local policy and process in relation to unified DNACPR
5. To explore perceived barriers when making DNACPR decisions
Further Advice & Support (East)

**Acute Hospital**
Resuscitation Officer: Jackie Cornes ext 3081
Acute EOL Facilitator: Emma Dixon and Kirsty Randall Tel 01625 666996
Macmillan Nurses: Specialist Palliative Care ext 3177, Lung ext 1997

**Community/Primary Care**
Macmillan GP: Dr John Mckay Tel 07715 362403
Head of EOL Service Development: Annamarie Challinor 07783628200
Macmillan Nurses: Specialist Palliative Care ext 3177, Lung ext 1997
Community EOL Facilitator: Jacquie Ball Tel 01606 555698

**Care Homes**
Macmillan GP: Dr John Mckay Tel 07715 362403
Care Home EOL Facilitator: Alison Colclough Tel 01606 555698
Care Home Training & Development: Elaine Griffiths Tel 07717 420091
Further Advice & Support (South & Vale Royal)

**Acute Hospital**
Resuscitation Officer: Susan Barber  Tel 01270 27(3560) bleep 3560  
Acute EOL Facilitator: Emma Dixon and Kate Estcourt  Tel 01625 666996  
Macmillan Nurses: Specialist Palliative Care  ext 2266

**Community/Primary Care**
Macmillan GP: Dr Sinead Clarke  Tel 07932 697883  
Head of EOL Service Development: Annamarie Challinor 07783628200  
Macmillan Nurses: Specialist Palliative Care  Tel 01606 544155  
Community EOL Facilitator: Jacquie Ball  Tel 01606 555698

**Care Homes**
Macmillan GP: Dr Sinead Clarke  Tel 07932 697883  
Care Home EOL Facilitator: Alison Colclough  Tel 01606 555698  
Care Home Training & Development: Gaynor MacGreagor  Tel 01625 264035
The North West End of Life Model

Do you expect your patient to live for...

- **Months Rather Than Years**
- **Weeks Rather Than Months**
- **Days Rather Than Weeks**