"DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION "(DNACPR):

SUPPORTING INFORMATION FOR HOSPITAL MEDICAL, NURSING, AHP & CARE STAFF

KEY POINTS about DNACPR DECISIONS

DNACPR Considerations:

Where **no explicit decision has been** made in advance, the initial presumption is to attempt Cardiopulmonary Resuscitation (CPR).

Within the hospital the **primary responsibility** for making and recording DNACPR decisions lies with the senior Doctor (Consultant/equivalent) who has medical responsibility for the patient at the time.

Decisions about CPR must be made on the basis of an **individual assessment** of each patient's case.

If the patient has an irreversible condition where death is the likely outcome, (e.g. end stage cancer, heart failure, multi-system failure) then their death should be allowed to occur naturally and peacefully. If death is inevitable, and the patient/family/carers know this, it is not usually appropriate to discuss a DNACPR decision.

A DNACPR decision applies **only to CPR** and **not** to any other aspects of treatment; nor does it override clinical judgement if there is an **immediately reversible** cause of respiratory or cardiac arrest (e.g. choking or anaphylaxis) - **unless** the patient has a valid applicable specific Advance Decision to Refuse Treatment (ADRT) to state otherwise.

Communication Considerations:

Discussions with patients should be undertaken with sensitivity, compassion and in an unhurried manner. Information leaflets about DNACPR decisions are available to all who may wish to consult them, including patients, families and carers.

It is not necessary to initiate DNACPR discussions/decisions unless the patient is felt to be at a high risk of a cardio-respiratory arrest (or should choose to discuss DNACPR).

If there is a raised risk of cardio-respiratory arrest and if resuscitation may be successful, **but** the potential benefits of CPR may be outweighed by the burdens of the patient's current and future condition, the patient's informed views must be sought (unless the patient declines this). If the patient lacks capacity, those close to the patient should be involved in discussions to explore the patient's wishes, feelings and values to help inform the medical decision.

Mental Capacity Considerations:

If a patient with capacity refuses CPR in advance, or a patient lacking capacity has a valid and applicable ADRT refusing CPR, this should be respected.

If a patient without capacity has appointed a Lasting Power of Attorney (LPA) for Health & Welfare they may legally help make the DNACPR decision, but cannot insist on CPR. The LPA person must be consulted and the clinician must ensure the section relating to giving the person authority – to refuse consent for life-sustaining treatment – has been completed in the original Lasting Power of Attorney.

Documentation you may see a DNACPR decision recorded in:

- Patient held unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) form (lilac form)
- In the patient's Medical notes

NB: A DNACPR form completed in the community is acceptable within the hospital setting, but it must be completed correctly, be deemed valid and be the original copy.