STANDARD OPERATIONAL PROCEDURE

For Senior Clinician Competencies and Assessment of Do Not Attempt Cardiopulmonary Resuscitation

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OPERATIONAL POLICY SUMMARY

This guideline outlines the standards for end-of-life care discussions about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions made by senior clinical staff that have completed training and competencies. This will support a person-centred approach in end-of-life care and allow natural death in the event of their heart stopping. It will ensure practice is evidence based including training, competencies, completing assessment, delivery, and management of end-of-life care across each organisation within Mid and South Essex (MSE) in partnership with organisations we are aligned. This standard operational procedure is for use within all Essex Partnership University NHS Foundation Trust (EPUT) services and across the wider MSE.

The Trust monitors the implementation of and compliance with this operational policy in the following ways:

End of Life Care Dashboard
Clinical Supervision
End of Life Care audit
Incident reporting e.g. Datix
Mortality review meetings
Record keeping

Services	Applicable	Comments
CHS	✓	**EPUT Integrated Teams in SEE and WE**
Acute and Community Hospitals	✓	**EPUT Community inpatients**
Hospices	✓	

OPERATIONAL POLICY TITLE

CONTENTS

1.0 INTRODUCTION

The aim of high-quality end of life care is to allow people to live and die well, with effective management of all their holistic needs. This includes early identification and effective planning, using a person-centred approach to discussion and informed choice. These elements of communication and inclusion are fundamental in good end of life care services. It is important that discussions, which involve Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, include completion of a DNACPR form so there is documented evidence and there is no attempt to restart the heart at the time of death. (Appendix 1- shows the current forms used within the EPUT/MSE services)

The Ambitions for palliative and end of life care: A national framework for local action 2021-2026 states:

'We cannot defeat death. However, we can change the way we talk about dying, death and bereavement and prepare, plan, care and support those who are dying and the people who are close to them.' P9

DNACPR discussions fit in the broader context of Advance Care Planning (ACP) and conversations are ideally started when someone is identified as being at the end of life. NICE (2019) describes end of life care in the following way:

End of life care includes the care and support given in the final weeks and months of life, and the planning and preparation for this. For some conditions, this could be months or years.

This includes people with:

- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are at increased risk of dying within the next 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life threatening acute conditions caused by sudden catastrophic events.

The DNACPR form must document those present during the conversation and decision process made, to support effective communication across services and boundaries. Although not a legally binding document, it communicates wishes, decisions and enables escalation to different services who may attend at the time of death.

A DNACPR decision is a clinical one based on the person's medical condition and their best interest, but it is important that the person and those important to them are involved at an early stage.

Effective communication will ensure decisions are understood by all present. It is important the conversation and decision making process is documented in the persons record, detailing how the decision has been made, who was involved and that the form and clinical records are completed, dated and signed.

The Care Quality Commission (2020) reviewed DNACPR decions during the Covid-19 pandemic and aimed to identify the impact of not discussing DNCAPR decisions at an appropriate time as part of a holistic conversation about advance care planning. The report acknowledges the unprecedented pressure that services and professionals have been under during the pandemic. The findings recommended a varied approach and emphasise how important the decision-making process is, as part of a holistic conversation about care.

It is important that the discussion is timely and undertaken with an appropriate clinician and that the form is completed without delay. On some occasions people and their loved ones are having multiple conversations to support the process for the form to be signed by a medical practitioner. Enabling senior clinicians to have these conversations will prevent delays and repetiton, and will improve the quality of care.

The CQC (2020) report and subsequent Bevan Brittan article (2021) set out recommendations that there needs to be information, training and support, with a consistent national approach to advance care planning and improved oversight and assurance. This includes ensuring staff have adequate training and competency to support DNACPR discussion and form completion.

Senior clinicians will only be able to complete this process if they have completed training and achieved a competency framework with support of their manager to sustain this process to sign off the DNACPR forms. A standard approach to training and competency framework will be supported and reviewed both within each of the provider organisations who adapt this approach and within MSE/EPUT integrated care systems.

2.0 PURPOSE

The purpose of this standard operational procedure is to provide a clear process to ensuring DNACPR forms are implemented with a person-centred approach, in a timely way and with reference to evidence. This ensures DNACPR is discussed with people who are receiving end of life care and the required DNACPR form is in place. This process will include:

- Clear guidance within this operational procedure.
- Training and support to those senior clinicians who are undertaking these competencies.
- Gaining an understanding on ethical and legal elements to DNACPR approaches.
- Training to support completion of the form.
- A competency framework that supports learning and ensures standards, capabilities and fitness to undertake this process are measured and assessed.
- The competency framework is incorporated into yearly appraisal and supervision with their manager. Individual organisations are required to

take on responsibility to support identified needs to update and maintain records of those staff with competencies.

- The MSE will support a yearly update from each of the provider organisations who support this practice and review/update this Standard Operational Procedure as a wider system approach. EPUT will support this within all areas where staff have been trained the line managers will maintain a register and shared within the localities within trust.

3.0 OVERVIEW AND DEFINITIONS

ACP – Advance Care Planning, is a process of formal decision-making that aims to record personal choice and preferences for people in advance of deterioration to help with their future care taking effect when they lose capacity.

Competency – "The state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of one's [professional] responsibilities."

Competency Framework – a document recording the evidence that the senior clinician has completed training and supervision within their role with appropriate sign off to undertake practice.

DNACPR Form – a do not attempt cardiopulmonary resuscitation document is a form that indicates a discussion with a patient and their relative who have prior knowledge that a medical decision to restart the patient's heart in the event of it stopping will not occur and they will be allowed to die naturally.

EPUT – Essex Partnership University NHS Foundation Trust

GSF – Gold Standards Framework is a systematic, common-sense approach to formalising best practice, so that quality End of Life Care becomes standard for every patient.

GP – The general practitioner that the patient is registered with is the care coordinator for patient care and prescriber of medications. They must be happy with the MDT decision.

LPA – lasting power of attorney (for health and welfare and/or finances).

MCA – mental capacity assessment and best interest document.

MSE – Mid and South Essex Collaborative, which includes organisations supporting health and social care working in partnership.

NELFT – North East London NHS Foundation Trust

Patient – For the purpose of this guidance this is the title used for the person who requires care.

Senior Clinician – A clinician who has a professional registration for their role who is working within a community or inpatient setting at a band 6 or above.

Specialist Palliative Care Team – a doctor, nurse or allied health professional who has extensive training and knowledge within palliative care. They may work within a hospice, hospital or community setting.

The Multidisciplinary Team (MDT) – GP and/or palliative care doctor and case Manager / hospice nurse and community nursing team and any other allied health professional involved in care. This should also include discussion with both the patient if they have capacity and the informal carer.

4.0 RESPONSIBILITIES

Organisational responsibility

- To support the implementation of this MSE Standard Operating Procedure or adapt to organisational requirements.
- To ensure a Standard Operating Procedure is in place and valid prior to sending staff on training.
- To ensure all incidents or critical incident analysis are fed back to the EPUT/MSE to support lessons learned.
- To participate in a yearly update at MSE/EPUT services to ensure system approaches and updates are reviewed and recorded accordingly.

Specialist Palliative Care/Senior Clinician with DNACPR Competency

- Ensure that the senior clinician has been trained, assessed and signed off competent to have discussions about DNACPR and complete the form.
- Ensure the person/carer/loved one has knowledge and a discussion supporting the form has been undertaken and recorded.
- Ensure the person/carer/loved one has the correct information leaflets and completed form to have at home.
- Ensure that discussion about any concerns with the Specialist Palliative Care Team and GP is recorded.
- Ensure that if a person lacks capacity an MCA has been completed and best interest decision is documented even if completed with an LPA.
- Ensure that all the relevant paperwork is scanned into electronic records.
- Ensure they send the appropriate referral to GP/single point of access/care coordination centre and community teams to ensure decisions are shared, recorded and communicated.
- Ensure that any changes are recorded on electronic records and communicated to the carer/loved one, GP and community nursing team.

GP/Medical team/ Palliative Care Consultant

- Ensure they are involved in supporting this process for people in their care.
- Take an active role in the MDT and GSF process and sharing the decision.

EPUT End of Life Care Sub-committee/MSE

- The End of Life Care Sub-committee in EPUT and MSE Palliative End of Life Care Delivery Group will support implementation of the approaches set out within this operational procedure within all areas/organisations.
- They will support a yearly review of the information, training and any necessary adaptions or approaches to DNACPR care competencies or change in national guidance.
- They will support the dashboard to record DNACPR.
- They will support an audit to establish any gaps, shared learning and effectiveness of senior clinicians taking on this role.

5.0 INCLUSION CRITERIA

- Valid consent from person and senior clinician.
- Person who meets the criteria for end-of-life care following assessment of prognostic indicators for end of life or has a high frailty score.
- Person/Carer/loved ones who have requested a DNACPR discussion and form to be completed.
- Senior Clinicians who have completed training and competency framework.

6.0 EXCLUSION CRITERIA

- No valid consent obtained.
- Any other concerns raised by a member of the MDT which are deemed to exclude the person.
- Senior clinicians who have not completed specific DNACPR training or obtained the relevant competencies.

7.0 REVIEW AND MONITORING

All senior staff that complete a DNACPR form and provide the medical signature must have undertaken the appropriate training and been supported to complete and pass a competency framework. This will include:

- Attending a formal training session related to DNACPR which covers:

- Communication skills to address difficult conversations, legal and ethical implications including completion of the form and record keeping in medical records.

- Recognition of their own limitations carrying out this role, how to utilise the multi-disciplinary team to support decisions as a best interest, including those people who lack capacity.

- To undertake supervision to assess competency and complete the competency framework for DNACPR which will support this role in practice.

- To have ongoing supervision and yearly appraisal to support this element of their role in their clinical practice and supported by their line manager.

- To be validated with the appropriate validation body for their profession and name current on the appropriate register i.e., Nursing and Midwifery Council and current on the NMC register.

- The line manager will hold a register of those staff with DNACPR competency and ensure that this is monitored in line with appraisal and supervision records.

- Any incident or complaint relating to DNACPR relating to a member of staff with competencies must be investigated by the clinical lead end of life care/appropriate manager for the organisation. This should be reviewed and feedback for lessons learned and will be escalated via Quality and Safety/governance meetings for learning and shared with the wider MSE and system partners.

- All incidents should be recorded via an incident report or Datix to support audit and lessons learned.

- The process should be reviewed in line with the Standard Operating Procedure update and must include system partnership approach across EPUT/MSE.

- Clinical audit which should include input from clinicians delivering training and those staff who hold the competency to be included in the audit/reflection/qualitative data/dashboard data to support effective review.

8.0 TRAINING

The training will be delivered as a standard approach across all areas in Essex, including hospice, acute and community settings.

Access to training will be supported by hospice, acute and community services who are able to deliver either virtually or face to face.

The same training and competency framework will be utilised to support partnership working and reduce variation in approaches/services within all areas of EPUT/MSE.

Senior staff will be required in participating in pre-course reading and understanding using a pre-course booklet.

Senior staff must attend all elements of the online/face to face training prior to undertaking completion of competency framework. This will involve two half days training.

Senior staff will be required to complete a competency framework document (Appendix 2) following the training and prior to undertaking the DNACPR process independently.

The manager for the individual achieving competencies must ensure they have signed off all areas of the competencies and recorded it within the member of senior staff's records. (Appendix 3)

The line manager must ensure there is a valid standard operating procedure in place to support this process within their organisation.

There must be ongoing opportunities to support competent individuals during supervision and appraisal and identify any other training needs.

For an update/review report to support audit within the systems in Essex to review the process in line with other services in EPUT/MSE. This should include input from clinical teams delivering training and those staff who hold the competency to be included in the audit should be reflection/qualitative data/dashboard data to support effective review and support outcome measures or future actions.

9.0 REFERENCE/BIBLIOGRAPHY

Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026.

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Appendix 1 – East of England DNACPR Form

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over
In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR)
All other appropriate treatment and care will be provided

Name:
Address:

Date of birth: / /
NHS number:

NHS
East of England

Date of DNACPR order:
/ /

Reason for DNACPR decision (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful [i.e. medically futile] because:

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

☐ Patient does not want to be resuscitated as evidenced by:

Record of discussion of decision (tick one or more boxes and provide further information)

Discussed with the patient / Lasting Power of Attorney [welfare]? Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives/carers/others? Yes ☐ No ☐
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

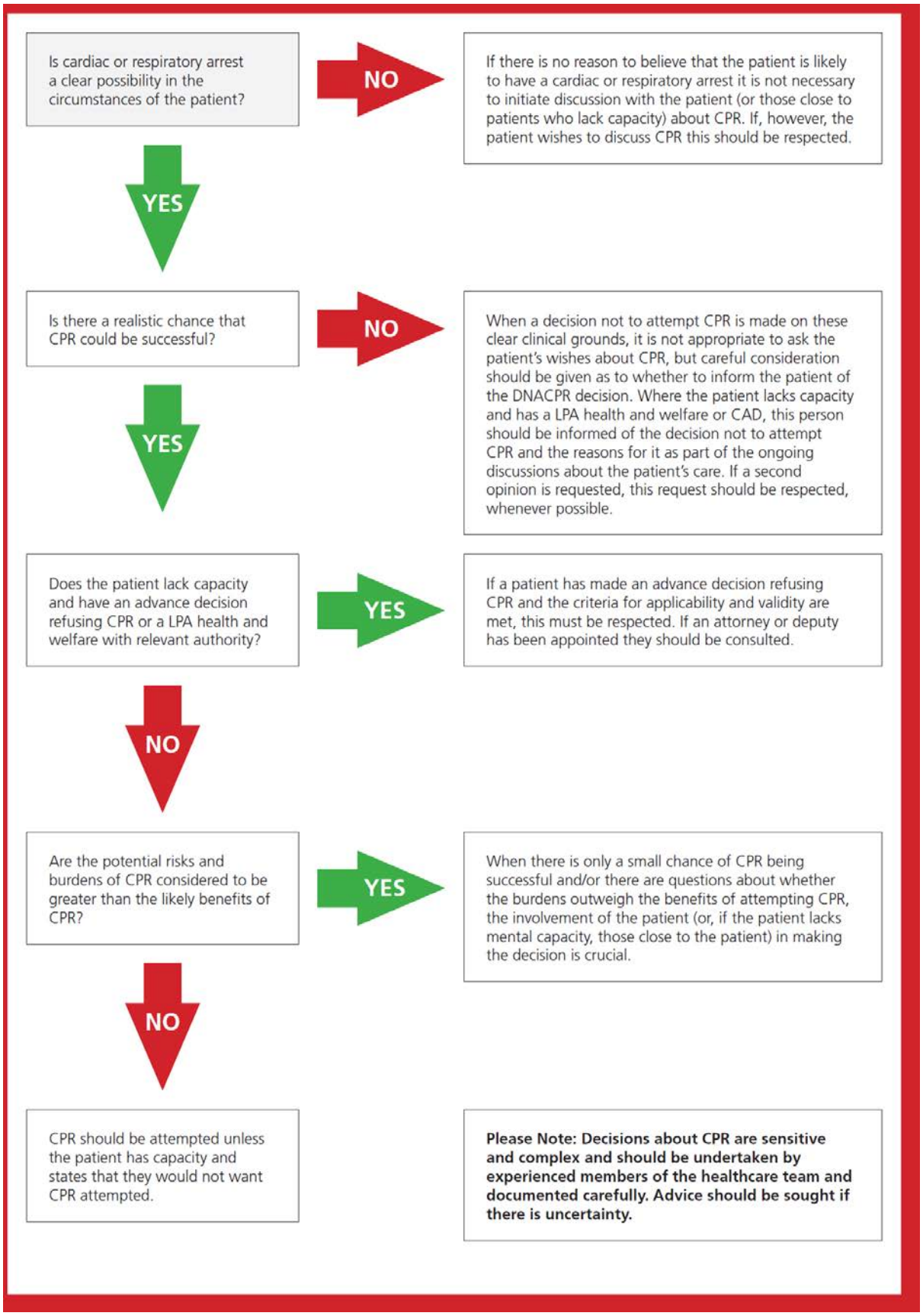
Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Healthcare professional completing this DNACPR order

Name: Signature:
Position: Date: / / Time:

Review and endorsement by responsible senior clinician

Name: Signature:
Position: Date: / / Time:
Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date: / /


Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?
NO
If there is no reason to believe that the patient is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with the patient (or those close to patients who lack capacity) about CPR. If, however, the patient wishes to discuss CPR this should be respected.
YES
Is there a realistic chance that CPR could be successful?
NO
When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient's wishes about CPR, but careful consideration should be given as to whether to inform the patient of the DNACPR decision. Where the patient lacks capacity and has a LPA health and welfare or CAD, this person should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussions about the patient's care. If a second opinion is requested, this request should be respected, whenever possible.
YES
Does the patient lack capacity and have an advance decision refusing CPR or a LPA health and welfare with relevant authority?
YES
If a patient has made an advance decision refusing CPR and the criteria for applicability and validity are met, this must be respected. If an attorney or deputy has been appointed they should be consulted.
NO
Are the potential risks and burdens of CPR considered to be greater than the likely benefits of CPR?
YES
When there is only a small chance of CPR being successful and/or there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial.
NO
CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.
Please Note: Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully. Advice should be sought if there is uncertainty.

Appendix 1 – Mid and South Essex University Hospital Group

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

NHS Mid and South Essex University Hospitals Group

ORIGINAL PATIENT COPY TO STAY WITH PATIENT

Name: (OR USE ADDRESSOGRAPH)

Address:

Postcode: Date of birth:

NHS number:

Date of DNACPR order:

Reason for DNACPR decision Document rationale in appropriate section below

CPR is unlikely to be successful [i.e medically futile] because:

Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

Patient does not want to be resuscitated as evidenced by:

Record of discussion of decision (tick one or more boxes and provide further information)

Does the patient have capacity? Yes ☐ No ☐

Has a Mental Capacity Assessment been completed and documented? Yes ☐ No ☐

Discussed with the patient / Lasting Power of Attorney [welfare?] Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives/carers/others? Yes ☐ No ☐
If 'yes' record full name, relationship to patient and content of discussion. If 'no' say why not discussed.

Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record full name, role and content of discussion. If 'no' say why not discussed.

Has this decision been documented in the patients' health care records? Yes ☐ No ☐

Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date:

Healthcare professional completing this DNACPR order

Name: Signature:

Position: Date: Time:

Review and endorsement by responsible senior clinician

Name: Signature:

Position: Date: Time:

Appendix 1 – Princess Alexandra Hospital

Name: .....
Address: .....
Date of birth: .....
NHS number: .....

NHS
The Princess Alexandra Hospital
NHS Trust

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

PATIENT/HOSPITAL COPY Adults aged 16 years and over **DO NOT PHOTOCOPY**

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

Date of DNACPR decision: / /

1 Does the patient have capacity to make and communicate decisions about CPR? **YES / NO**
If YES, go to box 2
If NO, are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If YES go to box 6 **YES / NO**
If NO, has the patient appointed a Welfare Attorney to make decisions on their behalf? If YES, they must be consulted. **YES / NO**
All other decisions must be made in the patient's best interests and comply with current law. **Ensure stage 2 Mental Capacity Act/Best interest assessment has been completed on opposite page before moving on to box 2.**

2 Summary of the main clinical problems and reasons why CPR would be in appropriate, unsuccessful or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney, state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multidisciplinary team contributing to this decision:

6 Healthcare professional recording this DNACPR decision:
Name ..... Position .....
Signature ..... Date ..... Time .....

7 Review and endorsement by most senior health professional:
Signature ..... Name ..... Date .....
Indefinite? YES / NO (If NO, complete review date box) → Review date:

8 Quality review from senior member of the nursing team:
Signature ..... Name ..... Date .....

DNACPRadult.1(2017)

Name: .....
Address: .....
Hospital no: ..... NHS no: .....
Date of birth: ...../...../..... Ward/Dept: .....

MCA/Best interest completed by two qualified staff

Name:	Name:
Signed:	Signed:
Grade:	Grade:
Date: ..... Time:	Date: ..... Time:

STAGE 2 MENTAL CAPACITY ACT/BEST INTEREST ASSESSMENT – DNACPR

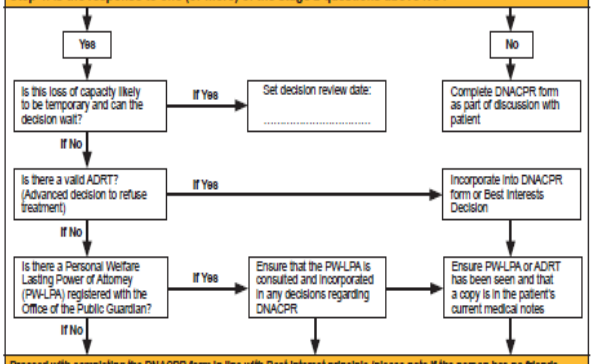
STEP 1. What concerns/triggers have given rise to this assessment of capacity?
Describe your concerns:

STEP 2. Stage 1 Document the reason you believe the individual has an impairment or disturbance of the functioning of the brain or mind.
Reason:

STEP 3. Stage 2 – Can the individual:

Understand information about the decision made? Give rational for this:	YES / NO
Retain that information in their mind? Give rational for this:	YES / NO
Use or weigh that information as part of the decision making process? Give rational for this:	YES / NO
Communicate their decision (by talking, using sign language or any other means)? Give rational for this:	YES / NO

Step 4. Is the response to one (or more) of the stage 2 questions above NO?



Proceed with completing the DNACPR form in line with Best Interest principle (please note if the person has no friends, relatives or unpaid carers then you must include IMCA services). Please document rational/Best Interest principle for DNACPR, be as specific as possible. Email a copy of MCA/Best Interest and DNACPR to PAHT Safeguarding Team.

Step 5. Document Best Interest outcome and decision:

Appendix 2 – Senior Clinician Competency Framework

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Senior Clinician Competency Framework Checklist			
1.	**Name of senior clinician applying for extended role**	PLEASE PRINT SURNAME: FORENAME (S):	
2.	**A. Clinical setting where senior clinician is employed** **B. Ward / department / GP practice and name and address of organisation supporting senior clinician**	☐ A& E ☐ GP Surgery ☐ Community ☐ Care Home ☐ Hospice ☐ Hospital ☐ Other Please state…….. …… …… …… ……	
3.	**Senior manager or line manager supporting extended role training. Include name and contact details (phone number and e-mail address)**	SURNAME: FORENAME:	Contact Details:
4.	**Training provider and assessor/mentor names** Suggested criteria for trainers: • Palliative Care education and training experience • Advanced Communication Skills Facilitator • Group Facilitation Skills Suggested eligibility for assessors/mentors: • Palliative Care Consultant	**Training Provider:** **NAME:** **ROLE:** **Organisation name and address:** **Assessor/mentor:** **NAME:** **ROLE:**	

Appendix 2 – Senior Clinician Competency Framework continued

	• GP experienced in End of Life Care Decision Making / Advance Care Planning • Line manager who has worked clinically as a palliative care specialist. • Consultant with whom a senior medic is working	

Appendix 2 – Senior Clinician Competency Framework continued

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
1.	Supports patients and families through uncertainty, using knowledge of the impact of disease and its treatments to discuss care options and coping strategies.	☐				
2.	Demonstrates respect, compassion, sensitivity and a non-judgemental attitude in complex situations.	☐				
3.	Recognises and takes the opportunity, by picking up on cues, to hold deeper discussions relating to psychological, emotional or spiritual issues demonstrating higher level communication skills.	☐				

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
4.	Analyses complex patient situations and shares experiences and insights with others.	☐				
5.	Acts as a good role model guiding and supporting other team members to improve their communication skills.	☐				
6.	Demonstrates an ability to ask potentially difficult questions and sensitively communicates "bad news" or contentious information or decisions.	☐				
7.	Creates an empowering and affirming environment which helps a patient make a difficult decision.	☐				
8.	Demonstrates the ability to effectively liaise and work in collaboration with multi professional staff working across the range of health and social care settings.	☐				

Appendix 2 – Senior Clinician Competency Framework continued

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
9.	Demonstrates advanced communication skills acquired through experiential learning or courses e.g. Connected Advanced Communication Skills Training.	☐				

KNOWLEDGE AND SKILLS COMPETENCIES

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
1.	Demonstrates degree level critical thinking and decision making as a minimum.	☐				
2.	Can provide evidence of continued professional updating "lifelong learning" with regard to end of life care.	☐				
3.	Able to recognise ▪ patterns of disease progression/ likely outcomes Able to use: ▪ Prognostic Indicator Guides to initiate timely end of life discussions and decision making.	☐ ☐				

Appendix 2 – Senior Clinician Competency Framework continued

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
4.	Takes into account competing ethical positions within clinical decision making.	☐				
5.	Fully aware of and utilises in their practice the following laws, policies and guidelines: ▪ Current law around DNACPR policies and the processes set out in the DNACPR policy ▪ Code of Professional Practice ▪ Mental Capacity Act 2005, Safeguarding Adults, Advance Decisions to Refuse Treatment and Advance Care Plans ▪ Coroners and Justice Act 2009 ▪ Human Rights Act 1998 ▪ End of Life Care Strategy 2008, updated 2010 and can demonstrate that they are embedded in their practice, guiding their decision-making processes.	☐				

HIGHER LEVEL DECISION MAKING COMPETENCIES

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
1.	Is able to critically assess, analyse and interpret complex: ▪ clinical situations ▪ communication ▪ best interest decisions.	☐				
2.	Demonstrates current experience of working in the contextual environment in which End of Life decisions are considered as part of daily practice e.g. working with patients with End of Life issues, palliative care or Long Term Conditions.	☐				
3.	Anticipates and recognises the changing clinical status of a deteriorating patient and is able to weigh the burdens/ benefits of investigations and treatments including cardiopulmonary resuscitation (CPR).	☐				

Appendix 2 – Senior Clinician Competency Framework continued

4.	Demonstrates knowledge of the evidence required to support the clinical justification of DNACPR	☐				
5.	Demonstrates the ability to practice, when appropriate, autonomously	☐				
6.	Works with individuals in shared decision making around treatment options, within the principles of valid consent and best interest e.g. appropriateness of CPR.	☐				
7.	Facilitates discussion on research & evidence based practice in advance care planning to include DNACPR.	☐				
8.	Identifies strategies of how to respond to any challenge to DNACPR decisions	☐				
9.	Applies professional judgement to make decisions and achieve appropriate care outcomes.	☐				
10.	Demonstrate the ability to identify priorities quickly and maintains focus when multiple stimuli are presented.	☐				

11.	Records in an accurate, detailed and contemporaneous manner the rationale for complex and best interest decisions.	☐				
12.	Demonstrates self-awareness of own limitations, prejudices and accountability and demonstrates being a reflective practitioner.	☐				

Appendix 2 – Senior Clinician Competency Framework continued

ORGANISATIONAL SKILLS COMPETENCIES

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
1.	Understands and adheres to the need for working within boundaries, processes and systems in complex situations.	☐				
2.	Demonstrates being innovative and self-directed in seizing the opportunity for DNACPR discussions.	☐				
3.	Demonstrates ability to work within a team and also independently in complex situations e.g. working with patients across transitional spaces such as liaison with hospital and community teams.	☐				

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Action Plan if required	Assessor's Signature on completion of Action Plan	DATE
4.	Supports junior staff to develop skills in organising, prioritising and delegating with regard to advance care planning to include DNACPR.	☐				
5.	Identifies and manages poor practice in end of life care, including recognition and reporting of clinical risk	☐				
6.	Uses leadership, supervisory and facilitation skills to: ▪ ensure awareness of changes in treatment plans, ethos of care ▪ Documents and communicates changes across all relevant health and social care domains with regard to DNACPR.	☐				

Appendix 2 – Senior Clinician Competency Framework continued

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Reflection/Discussion with Assessor	Assessor's Signature on completion of Action Plan	DATE
7.	Demonstrates ability to plan and organise complex activities and has shown diligence in completing projects, tasks and procedures with regard to end of life care.	☐				
8.	Demonstrates confidence and competence with IT systems i.e. computer literate, to enable communication of DNACPR decisions.	☐				
9.	To be able to facilitate DNACPR discussions via video consultation if needed.	☐				
10.	Be able to demonstrate the ability to complete accurate, detailed and contemporaneous records as per the Nursing and Midwifery Council standards with regard to DNACPR.	☐				

	COMPETENCY *Please discuss and complete with assessor prior to 1 day workshop*	Senior Clinician to self-assess by ticking box if fully competent	Reflection/Discussion with Assessor	Reflection/Discussion with Assessor	Assessor's Signature on completion of Action Plan	DATE
11.	Reflective practice: reflects on key skills & knowledge utilised / gaps with assessor after leading 1st DNACPR discussion	☐				

Appendix 2 – Senior Clinician Competency Framework continued

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Signing off Senior Clinician Competency Form

Name of senior clinician wanting to apply for extended role and Contact Details [Email, work address and tel no.]:

Line manager Name and Contact Details
[Email, work address and tel no.]:

Date and venue attended DNACPR Competency Workshop:

Assessor/Mentor Name and Role:

Assessed Candidate Competent?

Yes/Partially/No [please circle] If outcome is "partially" or "no" please detail reassessment process:

DATE: _____

Additional information:
Blank for your own notes:

Appendix 3 – Manager Statement of Competence

STATEMENT OF COMPETENCE

Team leader / assessor
I confirm that the practitioner has been trained and assessed competent as regarding conversations, legal, ethical issues relating to the implementation of a do not attempt cardiopulmonary resuscitation document - DNACPR and is competent to support discussion and implementation of the DNACPR document.

Signature:..... Name: ..... Date:.....

Practitioner
I confirm that I have completed my DNACPR competency training and I feel competent to deliver this element of care.

I certify that I am aware of my professional responsibility for continuous professional development and that I am accountable for my actions. I have made my manager aware of my competency and evidence of my competency is included with my CPD portfolio and annual appraisal.

Signature: .....Name: ..... Date: .....

I require further training or supervision.
My team leader / manager is aware of my competency deficits and my annual appraisal identifies learning needs to be addressed within the next 6 months through training and clinical supervision opportunities within my team.

Signature: ..... Name: ..... Date: .....

Team leader / Manager

Signature: ..... Name: ..... Date: .....

CHECK LIST FOR DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION - DNACPR

WHEN YOU RECEIVE SOMEONE INTO YOUR CARE IT IS YOUR RESPONSIBILITY TO CHECK THE DNACPR STATUS. THIS INCLUDES ENSURING THAT THEY HAVE A VALID FORM THAT HAS BEEN COMPLETED

Patient details must be legible and complete – a printed sticker is acceptable
Date of DNACPR order must be completed. A document without this is not valid

REASON

Diagnosis why medically futile: must be clear. It must clearly state END STAGE and list all co-morbidity.
Never accept if states: dementia, frailty or learning disability.
Good examples: dementia with co-morbidities End stage heart failure and COPD.
Why CPR would not be acceptable: should state something like prolonging suffering.
Patient does not want CPR: it must state the date of conversation and who was present.

RECORD OF DISCUSSION

All boxes must be ticked or crossed to indicate yes or no.
There must be a record of the discussion, which includes time, date and who was present at the conversation. This should also be recorded in medical notes. If a discussion has not been had then it is essential that it is recorded the reason why this did not happen.

HEALTH PROFESSIONALS COMPLETING THE FORM

The person who has written on the form and had the discussions should sign here as a record that it has happened. If it is the same person who is authorised to sign the form it should still be completed. Some ambulance crews may not accept it not completed

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN

This should always be completed with a signature, date and the position of the senior clinician.
Is DNACPR decision indefinite **Yes or No must be ticked or crossed**
If No is marked it must state a review date. It is not valid without the review date for an indefinite decision and if the review date has passed it is not valid.

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

NHS
East of England

DO NOT PHOTOCOPY

Name:	(OR USE ADDRESSOGRAPH)		
Address:			
		Postcode:	
NHS number:		**Date of birth:**	

ORIGINAL
PATIENT COPY TO STAY WITH PATIENT

Date of DNACPR order:

REASON FOR DNACPR DECISION (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful (i.e. medically futile) because:
☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:
☐ Patient does not want to be resuscitated as evidenced by:

RECORD OF DISCUSSION OF DECISION (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)? Yes ☐ No ☐ If 'yes' record content of discussion. If 'no' say why not discussed.
Discussed with relatives / carers / others? Yes ☐ No ☐ If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.
Discussed with other members of the health care team? Yes ☐ No ☐ If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date:

HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER					
Name:		Signature:			
Position:		Date:		Time:	

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN					
Name:		Signature:			
Position:		Date:		Time:	

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

NHS East of England

Name:	(OR USE ADDRESSOGRAPH)		
Address:			
		Postcode:	
NHS number:		**Date of birth:**	

COPY
FILE IN CLINICAL NOTES

Date of DNACPR order:

REASON FOR DNACPR DECISION (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful (i.e. medically futile) because:
☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:
☐ Patient does not want to be resuscitated as evidenced by:

RECORD OF DISCUSSION OF DECISION (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)? Yes ☐ No ☐ If 'yes' record content of discussion. If 'no' say why not discussed.
Discussed with relatives / carers / others? Yes ☐ No ☐ If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.
Discussed with other members of the health care team? Yes ☐ No ☐ If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date:

HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER					
Name:		Signature:			
Position:		Date:		Time:	

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN					
Name:		Signature:			
Position:		Date:		Time:	

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

NHS East of England

Name:	(OR USE ADDRESSOGRAPH)		
Address:			
		Postcode:	
NHS number:		**Date of birth:**	

COPY
FOR AUDIT

Date of DNACPR order:

REASON FOR DNACPR DECISION (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful (i.e. medically futile) because:

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

☐ Patient does not want to be resuscitated as evidenced by:

RECORD OF DISCUSSION OF DECISION (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)? Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives / carers / others? Yes ☐ No ☐
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date:

HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER					
Name:		Signature:			
Position:		Date:		Time:	

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN					
Name:		Signature:			
Position:		Date:		Time:	

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

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

YES ↓

Is there a realistic chance that CPR could be successful?

NO → When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient's wishes about CPR. However if a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it unless that would cause them severe distress. Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation. Where the patient lacks capacity and has a LPA health and welfare or CAD, this person should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussions about the patient's care. If a second opinion is requested, this request should be respected, whenever possible.

YES ↓

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

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

NO ↓

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

YES → When there is only a small chance of CPR being successful and/or there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial.

NO ↓

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

PLEASE NOTE: Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully. Advice should be sought if there is uncertainty.

Ref: DNACPR-3 [Revised 10.15]
To order additional DNACPR forms please telephone: **07855 404 409** or email: **twonineseven@me.com**

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Children less than 16 years of age

DNACPRpaed.2015)

Name _____

Address _____

Date of birth _____

NHS number _____

Date of DNACPR decision:

/ /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1 **1a. Does the child have capacity to make and communicate decisions about CPR?** If "YES" go to 1b. If "NO" go to 1c. **YES / NO**

1b. Has the child been involved in the decision-making process? Now go to 1c. **YES / NO**

1c. Have the child's parents (or those holding legal parental responsibility) been consulted and agreed to the application of this decision? If "YES" go to box 2. **YES / NO**

1d. Has a Court made an order in respect of this decision? If "YES" go to 1e. **YES / NO**

If the answers to both 1c and 1d are "NO", legal advice must be taken before proceeding. All other decisions must be made in the child's best interests and comply with current law.

1e. Date, time, location and name of Judge/Court making order:

2 **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child's best interests:**

3 **Summary of communication with child. If this decision has not been discussed with the child state the reason why:**

4 **Name of person(s) holding parental responsibility and summary of communication with them:**

5 **Names of members of multidisciplinary team contributing to this decision:**

6 **Healthcare professional recording this DNACPR decision:**

Name _____ **Position** _____

Signature _____ **Date** _____ **Time** _____

7 **Review and endorsement by most senior health professional:**

Signature _____ **Name** _____ **Date** _____

Review date (if appropriate):

Signature _____ **Name** _____ **Date** _____

Paediatric DNACPR Guidance Notes

Resuscitation Council (UK)

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

- The patient's full name, date of birth and address should be written clearly.
- The date of recording the decision must be recorded.
- This decision will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified.
- The decision should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the decision.

1. Child's capacity: Parental responsibility and decisions

- Record the assessment (using Fraser guidelines) of the child's capacity in the clinical notes.
- If the child is noted to have capacity but not included in the decision process a detailed, reasoned explanation for that should be included in the clinical notes and summarised in section 3.
- Record all discussions with those holding parental responsibility in the notes. Document all action points discussed with a clear indication of the absence or presence of parental agreement. Any disagreements that cannot be resolved should be discussed with your Trust's legal department for advice before recording a DNACPR decision.
- Record all communications with the courts.
- The date, time and name of the Court must be recorded in section 1e where the Court has been involved or made a formal ruling on the application of this decision. A copy of the Court order should be filed in the patient's health record.

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child's best interests

Be as specific as possible.

3. Summary of communication with child…

If this decision was not discussed with a child with capacity summarise the reason why this was inappropriate (Full detail should be recorded in the clinical notes). Otherwise state clearly what was discussed and agreed.

4. Summary of communication with persons holding parental responsibility

Whether or not the child has capacity their legal guardians (i.e. persons with parental responsibility) must be consulted. If the child has capacity and has been consulted great care must be taken to ensure that discussions do not compromise the clinician-child relationship. If the child and their guardians are not in agreement a legal opinion should be sought.

State the names and relationships of guardians with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. Members of multidisciplinary team…

State names and positions. Ensure that the DNACPR decision has been communicated to all relevant members of the healthcare team.

6. Healthcare professional recording this DNACPR decision

This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7. Review / endorsement …

The decision should be discussed with and endorsed by the most senior healthcare professional responsible for the child's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.

Essex Partnership University
NHS Foundation Trust

PROCEDURE: DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

PROCEDURE REFERENCE NUMBER:	CLPG14B
VERSION NUMBER:	3.1
KEY CHANGES FROM PREVIOUS VERSION	Addition of 4.9 and Appendix 4
AUTHOR:	Lucia Vambe, Advancing Clinical Practice Revised by Judith Skargon Nurse Consultant Physical Health
CONSULTATION GROUPS:	Operational Teams Trust wide, Compliance & Risk Team, Workforce & Training, Pharmacy Team, Physical Health Group.
IMPLEMENTATION DATE:	September 2017
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LAST REVIEW DATE:	July 2021 (addition of 4.8)
NEXT REVIEW DATE:	November 2022
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	October 2019
RATIFICATION BY QUALITY COMMITTEE:	November 2019
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PROCEDURE SUMMARY
This procedure is to provide guidance to all staff working within Essex Partnership University NHS Foundation Trust regarding the process of making, recording and reviewing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.
The Trust monitors the implementation of and compliance with this procedure in the following ways:
Through the Resuscitation and Deteriorating Patient Group who will review audit findings and clinical incident reports as appropriate.

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION PROCEDURE

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THIS IS AN INTERACTIVE CONTENTS LIST – PLEASE CLICK ON THE SECTION HEADINGS TO GO TO THE SECTIONS

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) PROCEDURE

1.0 INTRODUCTION

1.1 Cardiopulmonary resuscitation (CPR - attempting to restart the heart and breathing) can be attempted on any person in whom cardiac or respiratory functions have ceased (also referred to as a cardiac or respiratory arrest). Failure of these functions is part of dying and thus CPR can theoretically be attempted on any individual as part of an attempt to preserve life. However, because there comes a time when death is inevitable for every person, it is essential to identify patients for whom cardiopulmonary arrest represents a final event in their illness and in whom attempted CPR may be inappropriate. It is also essential to identify those patients who do not want CPR to be initiated.

1.2 It must be emphasised that every patient (and/or their family), for whom a DNACPR decision is considered, must be given the opportunity to be involved in the decision-making process, and be informed of the decision unless this would cause them harm, or they have stated that they do not wish to be involved or informed. This policy does not distinguish between basic and advanced resuscitation since the underlying ethical and legal principles about how decisions should be reached are the same.

1.3 It is most important however, that it is understood that a decision not to commence CPR does not in any way diminish the importance of on-going medical and nursing care. The change of focus of care should be effected by those involved in managing the patient and should be assisted by the appropriate palliative care.

1.4 It must be emphasised that the implementation of a DNACPR decision relates solely to the withholding of artificial ventilation and delivery of chest compressions to a person in cardiac arrest. All other treatments and interventions deemed appropriate will be given. The responsibility for making decisions about resuscitation lies with the Consultant or General Practitioner (GP) in charge of the patient's care.

1.5 Where a valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is not available in the Medical records (or appropriate location) and the precise wishes of the patient are unknown, cardiopulmonary resuscitation should be initiated if cardiac or respiratory arrest occurs.

2.0 SCOPE

2.1 This procedure applies to all staff (including voluntary workers, students, locum and agency workers) on all sites, within EPUT.

3.0 LEGAL ISSUES

3.1 In order to meet their obligations under the Human Rights Act (1998), health professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempted CPR include:

- The right to life (Article 2).
- To be free from inhumane or degrading treatment (Article 3).
- Respect for privacy and family life (Article 8).
- Freedom of expression, which includes the right to hold opinions and to receive information (Article 10).
- Freedom from discriminatory practises in respect of these rights (Article 14).

3.2 If any concerns arise regarding the application of a DNACPR order, the senior doctor in charge of the patient's care should be informed. If concerns still exist, the Medical Director should be informed and the advice of the Trust's legal advisors should be sought.

4.0 DNACPR DECISION

4.1 The British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

- Where the individual's condition indicates that effective CPR is unlikely to be successful
- When CPR is likely to be followed by a length and quality of life not acceptable to the individual
- Where CPR is not in accord with the recorded, sustained wishes of an individual who is deemed mentally competent or who has a valid applicable ADRT.

4.2 It is recommended that early decisions about CPR status and advance planning about limits of care should be made when patients are at risk of a cardiorespiratory arrest and there should be a clear and explicit resuscitation plan. In particular, consideration of this should be given to patients on older adult wards.

4.3 For situations when CPR might restart the heart and breathing of the individual, discussion will take place with that individual if this is possible (or with other appropriate individuals for people without capacity), although people have a right to refuse to have these discussions.

4.4 If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, health professionals will commence CPR in the event of a cardiac or respiratory arrest as per CPR Policy.

4.5 There may be some situations in which CPR is commenced on this basis, but during the resuscitation attempt further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR decision, or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be in appropriate.

4.6 When considering making a DNACPR decision for an individual it is important to consider the following:

- Is cardiac or respiratory arrest a clear possibility for this individual? If not, it may not be necessary to initiate discussion with the patient.
- If cardiac or respiratory arrest is a clear possibility for the individual, and CPR may be successful, will it be followed by a quality of life that would not be of overall benefit to the person? The person's views and wishes in this situation are essential and must be respected. If the person lacks capacity, a LPA will make the decision. If a LPA has not been appointed a best interests decision will be made.
- If the person has an irreversible condition where death is the likely outcome, they 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

4.7 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:

- The DNACPR decision is made following discussion with patient/others, this must be documented in the patient's medical notes and a clear and explicit resuscitation plan developed.
- The DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this, then a discussion with relatives/carers should only take place with the patient's permission. All discussions and decisions, including rationale must be clearly documented in the patient's records.
- If a discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, the reason for this must be clearly documented in the patient's medical notes**.**

4.8 This policy explicitly mandates that a DNACPR should not be applied to a group of patients under any circumstances. This is in line with CQC guidance. (CQC 2021)

4.9 The process by which a DNACPR decision is recorded and subsequently applied is detailed in the **STANDARD OPERATIONAL PROCEDURE For Senior Clinician Competencies and Assessment of Do Not Attempt Cardiopulmonary Resuscitation. (Appendix 4)**

5.0 DOCUMENTATION

5.1 Any decision relating to resuscitation must be communicated to the entire team of health professionals caring for that patient. A DNACPR decision should be reviewed on each transfer of care, but remains valid until it is reviewed.

5.2 The senior doctor is responsible for writing and authorising the order, then informing relevant clinical staff (e.g. nursing teams, other departments, and those areas required to be aware) that the order is in existence.

5.3 If a DNACPR decision is made, the doctor in charge of the patient's care (i.e. Consultant or GP) is responsible for ensuring that the DNACPR form is completed (as per Appendix 2) and the printed, signed original form is retained in the front of the patient's notes. Where the facility exists, a copy should be scanned onto the electronic patient record, for audit purposes.

5.4 If the patient is discharged or transferred to another healthcare establishment, whilst still subject to a DNACPR, the original DNACPR form MUST accompany the patient at all times.

5.4.1 Information needed on a DNACPR order:

- Patient's details.
- Date of decision.
- Assessment of patient's capacity.
- Clinical reasons for decision.
- Summary of communication regarding the decision with patient or their Attorney.
- Summary of communication with patient's relatives or significant others.
- Names of multi-disciplinary team members contributing to the decision.
- Name, position and signature of healthcare professional completing the decision.
- Review and endorsement by doctor in charge of the patient's care (Consultant or GP).

5.5 The original DNACPR form must be stored safely in the most appropriate place for the particular clinical environment. Where a physical set of notes exists, the DNACPR form should be filed at the front, however where electronic patient records are in existence an alternative system such as a 'DNACPR folder' should be agreed. Wherever the form is stored it must be immediately available in the case of an emergency.

5.6 In the community the DNACPR form should be kept safely in the patient's home and be accessible to all staff involved in their care. All staff should be aware of its existence. It is essential that the form goes with the patient when undergoing hospital treatment and is returned to them on discharge.

6.0 REVIEWING A DNACPR

6.1 The DNACPR decision will be regarded as **'indefinite'** unless:

- A definite review date is specified
- There are improvements in the patient's condition
- The patient's express wishes change

The frequency of review should be determined by the health care professional in charge of the individual's care.

6.2 It is important to note that the patient's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR is reviewed, the clinician must consider whether the person can contribute to the decision-making process each time. It is not usually necessary to discuss CPR with the person each time the decision is reviewed, if they are involved in the initial decision. Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

6.3 Prior to discharge from an in-patient facility, all DNACPR decisions should be reviewed and if the decision is to remain valid on discharge this needs to be communicated to the GP and community staff involved in providing support on discharge.

7.0 CANCELLATION OF DNACPR

7.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision by a doctor ST3 grade or above. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point pen and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional cancelling the order.

7.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision. The DNACPR form is then folded in half and filed at the back of the patient's medical notes.

7.3 If a copy of the DNACPR form is kept in the electronic patient records and the DNACPR decision is cancelled or suspended then the record must be updated to reflect this and steps must be taken to ensure that the DNACPR form does not appear to remain as a live document. For example on Mobius a request should be made to move the form to historical alerts via the 'report a problem' facility and a reason given. This should be done at the same time as scanning a copy of the 'cancelled' document.

8.0 SUSPENSION OF DNACPR

8.1 Uncommonly, some patients for whom a DNACPR decision has been established may have a cardiac or respiratory arrest from a readily reversible cause. In such situations CPR would be appropriate, whilst the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. It may

therefore be appropriate and necessary to ignore or override a DNACPR order or an ADRT and give treatment and/or resuscitation in such circumstances such as anaphylaxis or choking.

8.2 Some procedures could precipitate a cardiac or respiratory arrest, for example, induction of anaesthesia, surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the patient where applicable, will need to take place.

8.3 If a DNACPR decision is made on medical grounds, not in relation to a mental health condition and a person attempts to end their life, every reasonable attempt should be made to resuscitate the individual in this situation as the DNACPR form was not completed with the eventuality of suicide in mind.

9.0 LACK OF AGREEMENT

9.1 A patient with Capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an Advanced Decision to Refuse Treatment (ADRT). An ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the ADRT, but it is not essential. If the patient had capacity prior to a cardiac arrest event, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. The verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The patient should be encouraged to make an ADRT to ensure the verbal refusal is adhered to.

9.2 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a DNACPR form in their possession. An appropriate sensitive discussion with the patient should aim to secure their understanding and acceptance of the DNACPR decision. Fully documented discussion with relevant multi-disciplinary team members and family where possible would provide evidence of best practice. Additionally a second opinion may be sought in some circumstances.

9.3 Individuals do not have a right to demand that doctors carry out treatment against their clinical judgment. It may arise in rare cases that a clinical decision is seriously challenged and agreement cannot be reached, in these circumstances legal advice may be indicated.

10.0 PATIENTS WHO LACK CAPACITY

10.1 A person must be assumed to have the capacity to make a decision, unless it can be established that they lack capacity.

10.2 All decisions made on behalf of a person who lacks capacity must be made in that person's best interests. In the absence of a valid ADRT, DNACPR order, decision from a Court Appointed Deputy (CAD) or Lasting Power of Attorney (LPA), the person's best interests will be served by performing CPR, in an emergency.

10.3 If a decision relating to resuscitation is to be made, a 'decision-specific' assessment of the person's capacity must be made specifically relating to the DNACPR decision. Please refer to the Mental Capacity Act Policy and chapter 4 of the MCA Code of Practice for detailed information around assessing capacity. Assessments of Capacity should be clearly recorded on the Trust's Mental Capacity Assessment Form 1.

10.4 If the patient has an LPA in place, or a CAD, authorised to make decisions in respect of CPR, then the decision of the LPA/CAD should be respected

10.5 If the assessment shows that the person lacks capacity to make a decision relating to DNACPR, the decision must be made on their behalf using the best interest guidelines. These are set out in the MCA Code of Practice. In some cases not all of these factors will be relevant, and in others additional factors may need to be considered. Please refer to the Mental Capacity Act Policy and chapter 5 of the MCA Code of Practice for further guidance when determining best interest decisions. Best interest decisions should be made with involvement from the multidisciplinary team where possible and clearly documented, including as much information as possible on the Trust's Best Interest Decision Form, Form 3.

10.6 **Lasting Powers of Attorney**

An LPA is someone nominated by the patient to make decisions about health and welfare when he or she had capacity. For an LPA to be valid, it must be in a prescribed form, registered with the Court of Protection. For the LPA to be able to make decisions relating to CPR the patient must lack capacity and must have given authority under the LPA to give or refuse consent to life-sustaining treatment on their behalf. The LPA must act in the patient's best interests at all times.

10.7 **Family and friends**

It is a statutory requirement that family and friends are consulted if a patient lacks capacity and clinicians wish to act in his or her best interests. Friends or relatives of patients often believe that they will be the decision maker for the patient, however no person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision-making capacity, except where there is a LPA in place.

Clinicians have authority to act in the patient's best interests where consent is unavailable. People close to the patient should be kept informed and may be asked to reflect the patient's views and preferences, but it must be made clear to them that their role is not to make decisions on behalf of the patient. It is helpful for the clinician to ascertain known wishes of the patient, prior to the loss of

capacity, from family and friends whilst making a best interest decision. Details of discussions and those involved should be recorded on the MCA form and within the patient's records.

11.0 CHILDREN AND YOUNG PEOPLE

11.1 A child is someone under the age of 18. The MCA applies to anyone aged 16 and over but they cannot make an ADRT or give an LPA until the age of 18.

11.2 As a general rule, the wishes of a 'Gillick competent' child, who has sufficient understanding and intelligence to understand what is proposed by way of treatment, should be respected. Decisions relating to resuscitation should be made in full consultation between all relevant professionals and the parents. Staff should not rely solely on the wishes or directions of parents. Parents or anyone with parental responsibility must, however, be consulted as to whether the proposed contents of the Personal Resuscitation Plan (PRP) seem appropriate. Where feasible, the child's wishes should be obtained. (See http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html for basic information on 'Gillick competence')

11.3 It will normally be the case that the overall responsibility for drafting and reviewing PRPs rests with the Consultant Paediatrician. S/he should draft and review the PRP in consultation with the relevant nursing teams. The PRP must be recorded in the documentation.

11.4 If agreement cannot be reached as to whether CPR or other emergency treatment would be in the best interests of the child, e.g. there is an issue between staff and parents about the application of a PRP, a Court declaration should be sought.

11.5 The consultant and nursing team must ensure the plan is communicated to all those involved in the child's care. It must be ensured that schools where children subject to a PRP attend are fully aware of the PRP, are issued with copies and updates as necessary and that there is full and effective communication between all medical and nursing teams working with that particular child and school.

11.6 If a child is incompetent, in the absence of a PRP, staff should provide emergency treatment in child's best interests, using the same principles that apply to adults.

11.7 In an emergency situation, any doubt should be resolved in favour of preserving life.

12.0 COMMUNICATION

12.1 If the individual has 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 and friends must be respected. Where individual's lack capacity and their views on involving family and friends are unknown, health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individuals 'care and is not contrary to their interests'

12.2 Effective communication concerning the individual's resuscitation status will occur between all members of the multidisciplinary healthcare team involved and across the range of healthcare settings

12.3 For in-patients a DNACPR decision should be recorded on the handover sheet and resuscitation status should be verbally handed over at the start of each shift

12.4 Any additional measures used to communicate resuscitation status must be accurate and used consistently in the clinical area e.g. red dots on whiteboard, lists of patient resuscitation status.

13.0 TRANSFERRING PATIENTS

13.1 When transferring a patient, the original DNACPR form should be seen by the ambulance crew and remain filed in the accompanying medical notes or patient care record. Photocopied DNACPR forms or Personal Resuscitation Plan (PRP) should not be sent unless they are acceptable to the transferring ambulance service and receiving healthcare provider. They may accept a copy which they should sign to say they have seen the original.

13.2 **Internal transfers and all accompanied visits off Trust premises**
If the patient is transferred to another ward or hospital, the DNACPR order will remain in place until reviewed by the new consultant.

13.3 If a patient is taken off Trust premises and accompanied by a Trust member of staff, the original DNACPR order or PRP must travel with the patient and be adhered to if necessary.

13.4 **Transfers into EPUT Services**
Where a patient is transferred into an EPUT service with a current and applicable East of England unified form of DNACPR, this decision will be upheld until it is reviewed by the receiving consultant.

13.5 Where a patient is transferred with an existing DNACPR form, this should be checked for accuracy and completeness (See appendix 1), particularly with regard to discussion with relatives. If this discussion has not taken place, then arrangements should be made to address this as soon as possible with the patient's consent or as part of a best interest decision if they lack capacity.

13.6 **Transfers out of EPUT Services**
When a patient is transferred out of EPUT services with a DNACPR order, the original order must accompany them and should be reviewed by the GP or consultant taking charge of the patient.

14.0 REFERENCES

1. **British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing** (2016) Decisions Relating To Cardiopulmonary Resuscitation, Guidance from the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing, previously known as the "Joint

Statement", 3rd Edition (1st revision) 2016. https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

2. **Department of Health** (2005) *Mental Capacity Act 2005*

3. **Care Quality Commission** (20210 Protect, respect, connect – decisions about living and dying well during COVID-19 - CQC's review of 'do not attempt cardiopulmonary resuscitation' decisions during the COVID-19 pandemic Available at: https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf

4. NHS East of England Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] Frequently Asked Questions https://heeoe.hee.nhs.uk/palliative_dnacpr

5. **Health and Social Care Act** 2008 rev 2015

6. **Human Rights Act** 1998. Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents

7. **NICE** (2007) *Acutely ill Patients in hospital: Recognition and Response to Acute illness in Adults in Hospital,* London:NICE,www.nice.org.uk/CG50

8. **National Patient Safety Agency** (2008) Resuscitation in mental health and learning disability settings http://www.nrls.npsa.nhs.uk/resources/healthcare-setting/mental-health-service/?entryid45=59895&q=0%c2%accardiac+arrest%c2%ac
9. **NSPCC** A Child's Legal Rights: Gillick Competency and Fraser Guidelines (Accessed online 05/17) https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

10. **Office of the Public Guardian** (2013) Mental Capacity Act: Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

11. **Resuscitation Council (UK)** (2016) DNACPR https://www.resus.org.uk/dnacpr/

12. **Resuscitation Council (UK**) (2016) DNACPR Frequently Asked Questions *https://www.resus.org.uk/faqs/faqs-dnacpr/*

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