

Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACPR) 2018

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**JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION POLICY**

EXECUTIVE SUMMARY

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions can be difficult for patients, their relatives/ carers, and for clinical staff. This Policy brings together guidance from a number of national organisations and legal rulings, to provide robust, patient-centred direction for the Trust and its staff with regard to DNACPR decision making.

The Policy is intended primarily for JPUH staff, but in keeping with the Trust values of openness and transparency, it will be made available to patients and the general public through the Trust's website.

Good communication with patients and those close to them is essential when DNACPR decisions are being made and discussed, and the Policy aims to make this very clear. This Policy refers only to DNACPR decisions. There is a separate Trust Resuscitation Policy which covers issues pertaining to the provision and delivery of active CPR within the Trust.

This Policy fully complies with the guidance issued by NCEPOD (Time To Intervene, 2013 <http://www.ncepod.org.uk/2012cap.htm>), the latest BMA / RCN / Resuscitation Council (UK) guidance (2016, <https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/>) and the GMC (2012, http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp).

The JPUH guidelines are also consistent with the East of England unified regional guidelines (www.eoe.nhs.uk/dnacpr):

- it is essential to identify (a) patients for whom cardiopulmonary arrest is an anticipated terminal event and in whom cardiopulmonary resuscitation (CPR) is inappropriate; and (b) patients who do not want to be treated with CPR;
- all institutions should ensure that there is a clear and explicit resuscitation plan for all patients. For some patients this will involve a DNACPR decision;
- where there is no resuscitation plan and the wishes of the patient are unknown, resuscitation should be initiated if cardiopulmonary arrest occurs. However, a decision not to attempt resuscitation may be appropriate when the patient's condition indicates that CPR is unlikely to be successful, or CPR is not in accord with an applicable Advanced Decision¹ or successful CPR is likely to be followed by a length and quality of life that is not in the best interests of the patient.

This Policy is also in keeping with the Court of Appeal Ruling in the case of Tracey vs Cambridge University Hospitals NHS Foundation Trust and others (<http://www.judiciary.gov.uk/wp-content/uploads/2014/06/tracey-approved.pdf>) and the subsequent Resus Council (UK) statement on the case (https://www.resus.org.uk/pages/Statements/Statement_Tracey_judgement.pdf)

It has been updated to reflect the ruling in the Winspear vs City Hospital Sunderland [2015] EWHC 3250 (QB) case regarding patients who lack capacity.

¹ It is recommended that if there is any doubt about the clarity of an Advanced Decision for a particular patient that it should be discussed with the organisation's ethics committee / Senior Resuscitation Officer / Chair of Resuscitation Committee / Legal advisor as they can be both ethically and legally complex

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1.0 Introduction

1.1 Background

Many patients admitted to hospital, especially emergency admissions, are at risk of suffering a cardiac arrest. In some circumstances, clinical staff may try to re-start the patient's heart and breathing following cardiac arrest, a process known as cardio-pulmonary resuscitation (CPR). However only around 15-20% of patients undergoing CPR will survive to discharge from hospital, and many of those that do will be left in a very dependent state. The chances of survival following cardiac arrest are much lower than 15% in patients who are frail, very elderly or have multiple medical problems. CPR may result in rib fractures and witnessing CPR can be distressing for relatives and other patients. Inappropriate attempts at CPR deny patients and their relatives the opportunity for a peaceful, natural end of life.

The Trust has a duty to ensure that high quality CPR is available to those patients who would potentially benefit from it, which is covered in the Trust Resuscitation Policy.

However the Trust also has a duty to ensure that CPR is not forced on those who would not benefit from it or who would not wish to have it.

This Policy lays out the process by which the Trust will ensure that this duty is carried out in an appropriate, patient-centred and sensitive manner, and how the Trust will monitor compliance with this Policy.

1.2 Scope

This Policy applies to all registered Doctors, Nursing staff, Theatre Practitioners, Allied Health Care Professionals and staff deployed within clinical areas of the James Paget University Hospitals NHS Foundation Trust. The aim of the Policy is to describe the correct process for making, documenting and implementing DNACPR decisions.

In the interests of honesty and transparency, it will be made available to patients and members of the public through the Trust website, and has been written with this in mind.

1.3 Responsibilities

The Trust Resuscitation Committee, in conjunction with the Trust Resuscitation Officers will be responsible for implementing this Policy, training and updating staff, and monitoring compliance. Divisional Directors, Clinical Leads and Clinical Managers (including ward managers) will be responsible for ensuring compliance within their clinical teams.

1.4 Monitoring and Review

DNACPR decisions are subject to audit by the Resuscitation Department, as well as monitoring on the wards. The success of the Policy will be judged by the proportion of DNACPR decisions which are correctly documented on the relevant section of the Clinically Agreed Plan (CAP) Form and provide evidence of good practice as laid out in this Policy.

1.5 Related Policies and Further Information

This Policy fully complies with the guidance issued by NCEPOD (Time To Intervene, 2013 <http://www.ncepod.org.uk/2012cap.htm>), the BMA / RCN / Resuscitation Council (UK) (2016, <https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/>) and the GMC (2012, http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp).

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The Policy is also consistent with the East of England unified regional guidelines (www.eoe.nhs.uk/dnacpr):

This Policy should be read in conjunction with the Trust Resuscitation Policy and the Mental Capacity Act 2010

An information booklet for patients and those close to them is available in clinical areas and on the intranet. Its use is encouraged:

[http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20\(CPR\).pdf](http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20(CPR).pdf)

Further information for patients and public, in the form of a “Question and Answer” text and short video is available on the trust’s public internet pages:

[http://www.jpaget.nhs.uk/patients-visitors/cardiopulmonary-resuscitation-\(cpr\)/](http://www.jpaget.nhs.uk/patients-visitors/cardiopulmonary-resuscitation-(cpr)/)

An information booklet for staff regarding the Clinically Agreed Plan (CAP) form can be found in clinical areas and on the intranet:

[http://powwow/intranet/clientfiles/20151223154845_The%20Clinically%20Agreed%20Plan%20\(CAP\)%20Form%20-%20Staff%20Information%20Booklet.pdf](http://powwow/intranet/clientfiles/20151223154845_The%20Clinically%20Agreed%20Plan%20(CAP)%20Form%20-%20Staff%20Information%20Booklet.pdf)

1.6 Reader Panel

The following formed the Reader Panel that reviewed this document:

Post Title

Dr V Mahadevan, Director of Quality, Safety and Care
Dr J Crawford, Consultant ED Chair of Resuscitation Committee.
Dr B Auger, Medical Lead Specialist Palliative Care
Dr D Millican, Consultant Anaesthetist
Louise Barfield, Senior Resuscitation Officer
Julia Hunt, Director of Nursing
Jacky Copping, Deputy Director of Nursing
Hazel Stuart, Medical Director
Anna Hills, Deputy Chief Executive & Director of Governance

1.7 Trust Values

This Policy conforms to the Trust’s values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

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1.8 Glossary

The following terms and abbreviations have been used within this Policy:

Term	Definition
AD	Advance Decision
A&E	Accident and Emergency
BLS	Basic Life Support
CEAG	Clinical Ethics Advisory Group
CPR	Cardiopulmonary Resuscitation
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
CAP	Clinically Agreed Plan
FY2	Foundation Year 2 Doctor
HCP	Health Care Professional
NCAA	National Cardiac Arrest Audit
TNA	Training Needs Analysis

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet and will also be made available to patients and public through the Trust's public website.

2.0 Statement of Policy

CPR should be attempted for any person suffering a cardiac and/or respiratory arrest unless there is a clear, written directive to the contrary.

This Policy describes the process that should be followed when considering whether such a directive (a DNACPR decision) should be made, the discussions that should take place with patients and those close to them (as appropriate), and the documentation and communication that should accompany those discussions and the subsequent decision. It also describes the measures the Trust will take to monitor compliance with this process.

2.1 Policy Objectives

The overall objective of this Policy is to ensure all staff are aware of the Trust position with regard to DNACPR decisions and processes, and to guide them through the process.

3.0 Policy Details

The overall responsibility for decision about DNACPR orders rests with the Consultant in charge of the patient's care.

Adherence to the Mental Capacity Act (2005) which came in to force on 1st April 2007 is a legal requirement and should always be referred to when considering DNACPR orders and Advanced Decisions.

CPR should be attempted for any person suffering a cardiac and/or respiratory arrest unless there is a clear, written directive to the contrary.

If staff are absolutely certain that CPR would not be appropriate (e.g. rigor mortis or a terminally ill patient whose death is expected but the DNACPR directive cannot be found) then they may make a considered decision not to start CPR even in the absence of such a directive, but they must be prepared to justify this decision. Such "instant decisions" should be rare and would usually be made by experienced clinicians who feel competent to do so.

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A “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) directive applies solely to cardio-pulmonary resuscitation and should not influence the continued management or care of the patient. It is clearly stated on the East of England DNACPR form that “all other appropriate treatment and care will be provided”. The Trust Clinically Agreed Plan (CAP) Form has been designed to encourage discussion of other significant treatment options (such as Mechanical Ventilation) in addition to CPR, and allows for any other limitations of care to be specifically documented. The “CPR Status” section of the CAP form applies solely to cardio-pulmonary resuscitation and should not influence any other aspects of patient care.

The rights of the patient are central to any decision-making regarding resuscitation.

Individual circumstances and up-to-date guidance must be considered carefully before such a decision is made. If a patient with capacity refuses CPR or a patient lacking capacity has a valid and applicable advance decision refusing CPR, this should be respected.

Advice and support can be sought through the Resuscitation Service or the Clinical Ethics Advisory Group (CEAG) or the Trust’s Solicitors via the Risk and Governance Department. In an emergency, advice should be sought from the patient’s consultant in the first instance, and escalated to the on-call Executive team if necessary.

A flowchart (taken from the Resuscitation Council 2016 guidance) outlining the CPR decision making process is included in Appendix B and provides clinicians with a useful “quick reference” summary. This flowchart is printed in the Trust Admission Booklet (“Blue Book”) directly opposite the Clinically Agreed Plan (CAP) Form on which the CPR decision is to be documented and should be used as a guide to clinicians at the time of decision-making.

An information booklet “Your guide to decisions about cardiopulmonary resuscitation (CPR)” is widely available within the Trust and should be offered to patients (and/or those close to the patient, as appropriate) who would like more information about the process. A copy of this booklet is available on the intranet

[http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20\(CPR\).pdf](http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20(CPR).pdf)

3.1 In Circumstances where CPR would be clinically appropriate

The default position is that all patients should be “for CPR” unless there is a clear, written directive to the contrary. Where clinical staff feel that CPR would be appropriate and in a patient’s best interests, then the patient will be “for CPR”, unless the patient requests otherwise. As this is a standard part of active medical treatment there is no legal requirement to initiate discussion of CPR status with the patient in these circumstances.

The Clinically Agreed Plan form requires staff to actively document “FOR CPR” status, in keeping with NCEPOD guidance that a deliberate decision on CPR status should be made for all acute admissions. This should usually be done by a senior clinician (Consultant or Higher Specialist Trainee level) with sufficient experience to make a decision about the clinical appropriateness of CPR. In the event of a patient suffering a cardiac arrest before the CPR status section of the CAP form has been completed, the default position, as stated previously, is that a patient should be “FOR CPR”.

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If a patient wishes to decline CPR

If a patient with capacity (or the legally appointed healthcare power of attorney (proxy) of a patient without capacity) wishes to discuss CPR status then the clinical team should provide whatever information the patient seeks and have a sensitive discussion with the patient (or proxy), exploring their wishes and beliefs. An information leaflet is widely available within the trust and can be found on the intranet

[http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20\(CPR\).pdf](http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20(CPR).pdf)

If a fully informed patient with capacity (or the legal proxy of a patient without capacity), after such a discussion, declares a clear wish to refuse CPR (whether or not clinical staff believe it would be appropriate) then the patient's wishes should be respected and the "NOT FOR CPR" section of the CAP form should be completed, stating "patient's wishes" as the reason. In such a situation, because this is the patient's expressed wish, the "NOT FOR CPR" section of the CAP form can be completed by a junior doctor, so long as it clearly states that the decision is based on the patient's (or legally appointed proxy's) own wishes. The form should be countersigned by a senior clinician (Consultant or Higher Specialist Trainee level) at the first senior review, after confirmation with the patient.

3.2 In circumstances where CPR would be unsuccessful

Where there is no prospect of restoring heartbeat and breathing for any sustainable period, then the national and regional guidance is consistently clear that CPR should not be attempted or offered. In such circumstances the "NOT FOR CPR" section of the CAP form should be completed, stating clearly that CPR would be unsuccessful. In these circumstances it may not be appropriate to seek the patient's views or wishes regarding CPR, given that it would not be successful and therefore should not be attempted. The clinical team should however sensitively explain the decision to the patient as part of the wider discussion of the patient's condition and prognosis, and document this on the CAP form. If the patient does not accept the explanation that CPR would be unsuccessful then a second opinion should be offered and arranged in a timely manner (see Section 3.6). The guidance and legal precedent is clear that patients (and their relatives) have no legal right to insist on a treatment that is clinically inappropriate. However all reasonable attempts should be made to reach an agreement where a patient (or their relatives) requests that they remain "For CPR" in circumstances where the clinical team do not feel it would stand any chance of success. In the vast majority of such cases the situation can be resolved through a careful and sensitive discussion between a senior clinician and the patient (and/or those close to them), involving a full explanation of what CPR involves, how likely it is to stand any chance of success, and with reassurance that a DNACPR decision only applies to CPR and will not affect any other aspects of care.

For some patients, particularly those at the end of life, discussions regarding non-treatment may be distressing. However the Court of Appeal ruling in the Tracey vs Cambridge University Hospitals and others case makes it clear that the clinical team have a duty to inform the patient of a DNACPR decision unless doing so would cause "physical or psychological harm" to the patient, and that avoiding "distress" is not a valid reason for not informing the patient. This should be done sensitively, and if the patient makes it clear that they do not want to talk about it any further then this should be respected and documented. In the very rare circumstance that the clinical team feel it would cause actual harm to inform the patient of a DNACPR decision then the clinical team should document their reasoning in full in the clinical notes and give careful consideration to informing the patient's family of the DNACPR decision, provided that the patient has given consent for the clinical team to discuss their clinical information and treatment with them. If the patient has withheld consent for medical staff to discuss their clinical information with the family or those close to them then this must be documented on the DNACPR directive.

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Where a patient lacks capacity, the clinical team must make all reasonable effort to contact the patient's healthcare power of attorney (if one has been appointed) or their next of kin or those close to the patient before a DNACPR decision is made. Again, this should occur as part of a sensitive discussion of the patient's overall prognosis and treatment, and the conversation must be documented on the CAP form. It is important to convey that a DNACPR decision is intended to spare the patient traumatic and undignified treatment that will be of no benefit, not to withhold life-saving treatment or any other care that they need. If the healthcare power of attorney or next of kin/those close to the patient disagree with the decision then a second opinion should be offered and arranged in a timely manner (see Section 3.6). If a patient without capacity has no next of kin or close family/ friends, the Mental Capacity Act requires that an Independent Mental Capacity Advocate (IMCA) be consulted for all decisions about "serious medical treatment", including CPR. However the Resus Council (UK) guidance states that if a CPR decision is needed when an IMCA is not available, the decision should be made on clinical grounds and involvement of an IMCA should take place at the first available opportunity.

In an emergency where cardiac arrest appears imminent and the clinical team feel that CPR would not be appropriate in a patient who lacks capacity, and have made all reasonable effort to contact the patient's relatives, then a DNACPR decision can still be made on clinical grounds. The attempts to contact the relatives should be documented, and ongoing attempts to contact them should be made (and documented) even after the form has been completed.

It may be useful to provide an information leaflet, which is widely available within the trust and is on the intranet

[http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20\(CPR\).pdf](http://powwow/intranet/clientfiles/201592110326_Your%20guide%20to%20decisions%20about%20cardiopulmonary%20resuscitation%20(CPR).pdf)

3.3 In circumstances where CPR might be successful but may not be in the patient's best interests

Whilst CPR may restore heartbeat and breathing for a sustainable period in as many as 40% of those who receive it, the underlying cause of the cardiac arrest will remain, and many patients will suffer neurological damage as a result of the cardiac arrest. Only 15-20% of patients receiving CPR following a cardiac arrest will survive to hospital discharge, and many of these will not regain their previous level of independence or neurological function. Some patients may survive as a result of CPR, but be left in a comatose or completely dependent state.

In some circumstances, the clinical team treating a patient may believe that CPR might be successful in restoring a patient's heartbeat and breathing but may feel that the resultant quality of life would not be acceptable to the patient. In such circumstances, the views of the patient are absolutely essential, as only the patient themselves can decide what they would consider to be an "acceptable quality of life".

Where such a "best interests" decision is being considered, the clinical team must sensitively explore the issues with the patient and ascertain what their views are. The patient should be given as much information as they would like, including an accurate description of what CPR involves, an assessment of the likely outcome of a CPR attempt and any doubts whether the burdens and risks of CPR interventions would outweigh the benefits.

In the vast majority of cases, patients tend to reach the same conclusion regarding CPR as their clinical care team.

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In a small percentage of cases, even after being given full information and realistic advice on likely outcomes, a patient may express a wish to receive CPR even where the clinical team feel it would lead to a very poor outcome. Such a wish should usually be respected, but the clinical team may seek a second opinion if they disagree with the patient's decision.

If the patient lacks capacity and a "best interests" DNACPR decision is being considered then the clinical team must seek to establish the patient's views from those close to the patient.

Where the patient has a legally appointed Healthcare Power of Attorney, then the clinical team must involve them in any decision regarding CPR, as they have the authority to make decisions for the patient. The existence of a Healthcare Power of Attorney may be apparent in the patient's medical records, or may be relayed to staff by the patient themselves or those close to the patient. If it is not clear whether such a Power of Attorney exists, staff should actively contact the patient's next of kin to find out.

In the absence of such a legally appointed proxy, the clinical team should sensitively seek to establish what the patient's views would be by speaking to the patient's next of kin or others close to the patient. It should be made absolutely clear that these people are not being asked to make a decision for the patient, but to represent the patient's views so that the clinical team can make an informed decision. The responsibility for making a decision remains with the clinical team.

If the patient lacks capacity and has no next of kin or close family/ friends to help guide the clinical team in making a "best interests" decision, then Resus Council guidance states that an Independent Mental Capacity Advocate (IMCA) should be consulted. An IMCA does not have the power to make a decision about CPR status but will help the team in determining the patient's best interests. If an urgent decision needs to be made at a time when an IMCA is not available, then the clinical team must make the decision based on their own assessment of the patient's best interests and discuss the decision with an IMCA at the earliest opportunity.

In an emergency where cardiac arrest appears imminent and the clinical team feel that CPR would not be in the best interests of a patient who lacks capacity, and have made all reasonable effort to contact the patient's relatives, then a DNACPR decision can still be made on clinical grounds. The attempts to contact the relatives should be documented, and ongoing attempts to contact them should be made (and documented) even after the form has been completed.

The discussion with the patient, or those close to them, should be documented on the Clinically Agreed Plan (CAP) form (or in the clinical notes if the outcome of discussion is a "FOR CPR" decision) and the rationale for the decision clearly documented.

In a small percentage of cases, even after being given full information and realistic advice on likely outcomes, the Healthcare Power of Attorney or those close to the patient may feel strongly that the patient would wish to receive CPR even where the clinical team feel it would lead to a very poor outcome. Such a wish should usually be respected, but the clinical team may seek a second opinion if they feel this is genuinely not in the patient's best interests. This should be documented.

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3.4 Communicating DNACPR decisions to those close to the patient

For patients who lack capacity, any DNACPR decision must be communicated to their Healthcare Power of Attorney or next of kin or those close to the patient. This paragraph describes the process for communicating DNACPR decisions to relatives of patients who DO have capacity.

It is normal for relatives and close friends of patients to want to be aware of important decisions that are made about their care, and CPR decisions are no exception to this. However standard principles of confidentiality apply and the patient's consent should be sought before informing family members or others close to the patient of any DNACPR discussions. If a patient asks that their family or anyone close to them be involved in the discussions, then this should be accommodated. Where the family or others close to the patient have not been involved in the discussions between the patient and the clinical team, you should seek the patient's agreement to share the DNACPR information with family members, close friends or carers at the earliest opportunity following a DNACPR decision. It may be appropriate for the patient to tell family members or others themselves, if they are happy to do so, with support of the clinical team if desired. Alternatively, if the patient would prefer the clinical team to talk to the family or others close to them on their behalf, then this should be arranged. The decision as to who will inform those close to the patient, and the record of that discussion, should be recorded on the CAP form and in the patient's notes.

A minority of patients may express a wish for their family or others close to them not to be informed of a DNACPR decision. In such circumstances, the patient's views should be explored and clinical staff should offer to help the patient broach the subject with the family or others close to them. If, despite this, a competent patient is clear that they do not wish their family or others close to them to be told of the DNACPR decision, then the clinical staff must respect the patient's right to confidentiality and the patient's decision should be clearly documented on the CAP form and communicated to all members of the clinical team.

3.5 Restricted CPR attempts

A patient should be either "For CPR" or "Not For CPR". We do not advocate the use of "limited CPR" in advanced plans such as the CAP form – it is up to the cardiac arrest team to make decisions on the duration of the resuscitation attempt based on the circumstances of that specific cardiac arrest, the cardiac rhythm and the response to treatment.

In the Intensive Care Unit where patients are on continuous cardiac monitoring and already receiving organ support, it may be appropriate in some patients to use a "Shockable Rhythms Only" limitation to CPR. Such a decision should only be made by a consultant and the reasons for it must be documented in the patient's notes. Detailed instructions of how that decision should be implemented must also be included in the patient's notes, unless there is an agreed standard implementation of such a restriction that is understood by all staff in the unit. On discharge from ICU to a general ward, this decision must be reviewed and replaced by a clear "For CPR" or "Not for CPR" instruction.

3.6 Temporary Suspension of DNACPR decisions

In certain circumstances patients with a "DNACPR" directive may have specific interventions appropriate to their care that carry a risk of cardiac arrest i.e. induction of anaesthesia, anaphylaxis or other procedure which may precipitate a cardiac arrest. In such circumstances, cardiac arrest may be more easily and rapidly reversed than a "natural" cardiac arrest. In these situations it may be appropriate to revoke the decision unless the patient has specifically refused intervention in these circumstances. This should be discussed with the patient (and/ or legal proxy or family/carers as appropriate). The time at which the decision is reinstated should be discussed, agreed and documented. The

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Association of Anaesthetists of Great Britain and Ireland provides guidance on this matter for patients undergoing anaesthesia (http://www.aagbi.org/sites/default/files/dnar_09_0.pdf). Where a decision is temporarily revoked this must be communicated to all relevant staff (eg. during the Team Briefing prior to a surgical procedure) and clearly documented in the patient record (eg. on the anaesthetic chart). The time of reinstatement of the DNACPR decision should also be clearly documented and communicated to all relevant staff (eg. Recovery staff or receiving ward staff following a surgical procedure).

3.7 Second Opinions

In the rare event of there being an irreconcilable disagreement over CPR status between the clinical team and the patient (or the Healthcare Power of Attorney or next of kin or others close to a patient who lacks capacity), then a second opinion should be sought.

If a DNACPR decision is challenged by a patient or those close to the patient, the DNACPR decision should be temporarily suspended until a second opinion has been obtained, and this must be very clearly marked on the CAP form by writing "Suspended pending second opinion" in large letters diagonally across the form.

The second opinion should be provided in a timely manner by an experienced clinician (usually a Consultant) with a full understanding of the clinical and ethical considerations of providing CPR. Suitable individuals might include ICU Consultants, senior physicians and members of the Resuscitation Committee. The Resuscitation Officers and/or resuscitation committee chair should be approached when a second opinion is required and will assist in the process.

The outcome of the second opinion will determine whether the DNACPR decision is annulled (by marking "VOID" in large clear letters across the form) or reinstated. A new CAP form should be completed to reflect the outcome of the second opinion and the discussion that has taken place.

In the event that disagreement is not resolved by the second opinion, then the matter should be escalated to the Medical Director (or Deputy Medical Director in Medical Director's absence) to provide a third opinion. The Medical Director (or Deputy MD) may provide this third opinion directly themselves, or may choose to arrange for a suitably qualified and experienced deputy to provide the third opinion on their behalf. Again, the decision should be temporarily suspended until the third opinion has been provided. The clinician providing the third opinion should make sure they are fully informed of the reasoning behind first and second opinions, ideally by speaking directly to the clinicians who gave those opinions.

3.8 DNACPR documentation

It is the responsibility of the Consultant in charge of the patient's care to ensure that when any decision either "FOR CPR" or "NOT FOR CPR" is made, it is clearly documented in the patient's notes and communicated to the healthcare team.

The Trust introduced a new form, the Clinically Agreed Plan (CAP) Form in September 2014, with the express aim of documenting a conscious decision "FOR CPR" or "NOT FOR CPR" for every acute admission, and to encourage clinicians to make shared decisions with patients (or those close to them, if the patient lacks capacity) about other aspects of care that might not be appropriate or might be against the patient's wishes. These include invasive treatments such as Mechanical Ventilation and ITU admission and treatments such as Blood Transfusion that may be refused by patients on grounds of religious or personal belief. These are simply examples, and the CAP form can be used to

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document ANY treatment decisions that have been agreed between the clinician and the patient.

The CAP form is attached as appendix C of this policy document.

The CAP form has a clearly marked section for recording CPR status, and for documenting the discussion that has taken place with regard to this decision.

Once a DNACPR decision has been made the “NOT FOR CPR” section of the CAP form MUST be completed (see Appendix C). Each section on the form must be completed giving brief explanation of the reason for the decision and whether the decision has been discussed and communicated with the patient and/or family or others close to the patient. The instruction must be signed, with the name of the person responsible for the decision printed clearly and legibly as well as the date and time.

If a patient is deemed not to have capacity, or if there is any doubt as to their capacity, then a 2-stage assessment of capacity MUST be carried out (in accordance with Trust policy) using the template printed opposite the CAP form in the Blue Book, or the Trust’s standard Capacity Assessment green sticker. The outcome of the capacity assessment must be recorded in the appropriate section of the CAP form.

If a DNACPR decision has been made and no discussion with the patient and/ or family or others close to the patient has taken place this MUST be clearly documented on the CAP form (and in the clinical notes if extra space is needed), as must the reason for non-communication. It is the responsibility of the senior nursing staff to communicate to all healthcare professionals involved that a DNACPR decision has been made and the DNACPR process check must be followed. Where it has not been possible to contact family members or others close to the patient when a DNACPR decision has been made, repeated efforts should be made to contact them and these efforts and the outcome of the contact should be documented and dated on the CAP form and in the patient’s clinical notes.

The Clinically Agreed Plan Form is unique to this Trust and is not valid outside of the trust. Other acute hospital trusts will have their own DNACPR documentation, and there is a standardised East of England DNACPR form (appendix D) which is recognised across all settings in the region, including in the community and during ambulance transfers. Some trusts and regions are also using the ReSPECT form, which is similar in purpose and content to the CAP form.

When a patient is admitted to JPUH with an East of England DNACPR form (or other valid DNACPR form, including the ReSPECT form) already in place, the admitting medical staff should confirm with the patient (or those close to the patient as appropriate) that they wish the DNACPR decision to remain in place during the hospital admission, and should complete the CAP form accordingly. A copy of the original DNACPR form can be added to the clinical notes as a record, but the original East of England DNACPR form should remain in the possession of the patient or those close to them for use when the patient is discharged back to the community.

For patients who are being transferred to another hospital, discharged home, or to a community care setting, it may be appropriate for the DNACPR decision to remain in place, or be revoked, depending on the views of the clinical team and the patient (or legal proxy/ those close to the patient). If it is agreed that the DNACPR decision should remain in place, clinical staff should ensure that the patient/legal proxy (and family if the patient wishes/ lacks capacity) is in agreement with this, and a copy of the East of England community DNACPR form (appendix D) should be completed and accompany the patient

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on transfer/discharge. A copy of the CAP form may be attached to the DNACPR form to act as documentation of earlier discussions/ consultant input. The receiving care team (including GP) and transfer team should be made aware of the DNACPR decision. If a decision is revoked on discharge, then the CAP form should be clearly marked "VOID", with a date and a reason. Again, the patient and family should be informed and in agreement with the change in status.

3.9 Reviewing CPR status

CPR status should be reviewed on each consultant ward round and in response to any significant change in a patient's condition. In particular, where a CPR decision was made at a time when a patient lacked capacity, and the patient subsequently regains capacity, then CPR status should be reviewed in discussion with the patient. CPR status should also be reviewed if the patient or family request a review, if any staff member feels it needs reviewing, and on transfer between wards. CPR status must be reviewed as part of discharge planning, and an East of England DNACPR form should be completed prior to discharge if the clinical team and patient (and/or, where appropriate, those close to the patient) agree that the decision should remain in place on discharge – see preceding paragraph.

Where a review of CPR status results in a change of that CPR status (i.e. from "FOR" to "NOT FOR" or vice versa) then the CAP form should be marked clearly as "VOID" and a new form should be completed and stapled over the voided form. Blank CAP forms can be printed off the intranet for this purpose (http://powwow/intranet/clientfiles/2015716143725_2015616105751_CAP%20page%201.pdf).

A detailed record of the reason for the change in status should be made in the clinical notes.

Where a detailed review of CPR status has occurred (such as when a patient regains capacity, or if a patient or those close to them request a review) but has not resulted in a change of status, a record of the review and any discussions should be written in the clinical notes.

3.10 Advance Decisions

Where a patient has a clear and valid Advance Decision, this should be taken into account and respected when DNACPR decisions are being considered.

An Advance Decision (AD) is a record of what treatment a person specifically refuses should they lose the mental capacity to make such decisions in the future.

At law, an adult patient with mental capacity has the right to refuse medical treatment, even if that refusal may lead to their death. This right includes the right to decide in advance what treatment to refuse should he/she becomes incompetent or unable to communicate his/her wishes.

Under the Mental Capacity Act 2005 an Advance Decision to refuse treatment, including life sustaining treatment will be valid and legally enforceable should certain criteria be met.

There are overriding principles when managing an AD

- The person may have a written AD. If the patient has capacity and can communicate, then normal consent principles apply. An oral or written AD can be withdrawn by any means (oral or in writing) at any time by a patient who has capacity and is able to communicate the decision to withdraw the AD.

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- A suicide note is not considered to be an AD. Assisted suicide or euthanasia remains a criminal offence in the United Kingdom.
- If the lead clinician is unwilling to deliver care within the boundaries articulated by an AD, then they are personally responsible for transferring of care of the patient to an appropriate colleague. The lead clinician remains accountable for the patient's care until this is achieved
- An AD cannot be used as a means of insisting upon a particular form of treatment.
- An AD cannot authorise treatment or any action which is unlawful, including assisted suicide.
- An AD must acknowledge that the refusal of treatment may lead to death.
- If a person wishes to amend or update a written AD, the changes must be made in writing and appropriately dated and witnessed. Ideally a new AD document should be drawn up to incorporate the changes and all existing copies of the old AD should be marked clearly as "Void".

Requirements of a valid AD

In law there is a presumption that the adult has the capacity to consent or refuse treatment.

Under the Mental capacity Act 2005 an AD to refuse general (not life sustaining) medical treatment will be valid and legally enforceable if:

- The person was 18 years or over when making the decision
- It was made after the Mental Capacity Act (therefore dated)
- It is in writing, signed and legible
- It is witnessed and countersigned by a person 18 years or over with capacity
- The person had mental capacity when making the decision
- It makes clear which treatments are to be refused. Medical terminology need not be used as long as the intention is clear
- It explains the circumstances to which the refusal refers (eg. Ventilator dependence, irretrievable loss of ability to communicate)
- The person was not pressurised or unduly influenced into making the decision
- The person is now incapable of making a decision or expressing their wishes
- It has not been changed by the patient either verbally or in writing
- It applies in a clear and unambiguous way to the medical situation the patient is currently in
- If the AD includes refusal of life-sustaining treatment or CPR, it must explicitly state that the AD is to apply even if the person's life is at risk

Appendix E provides a standard checklist to assist staff in ascertaining whether an AD is valid.

3.11 Children and DNACPR Decisions

DNACPR decisions in children are an uncommon occurrence and should take place as part of a lengthy and detailed communication between clinical staff, the parents and, where appropriate, the child themselves (dependent on their age/ ability to understand the matters being discussed).

The person with parental responsibility may give consent for any medical intervention (including CPR) for any child or young person up to the age of 18 years although the age of consent is 16 years. However if a child is under 16 years and is judged competent to make decisions he/she can give consent for any treatment without the person with

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parental responsibility. Full discussion with parents should be encouraged. However the child or young person cannot withhold consent for life saving treatment.

The specific needs of the child must remain the priority within a child orientated consultation process.

The key position of the parents must be acknowledged but there should be no obligation on the caring team to give futile and/or burdensome treatment even with dissent from parents and/or other professionals.

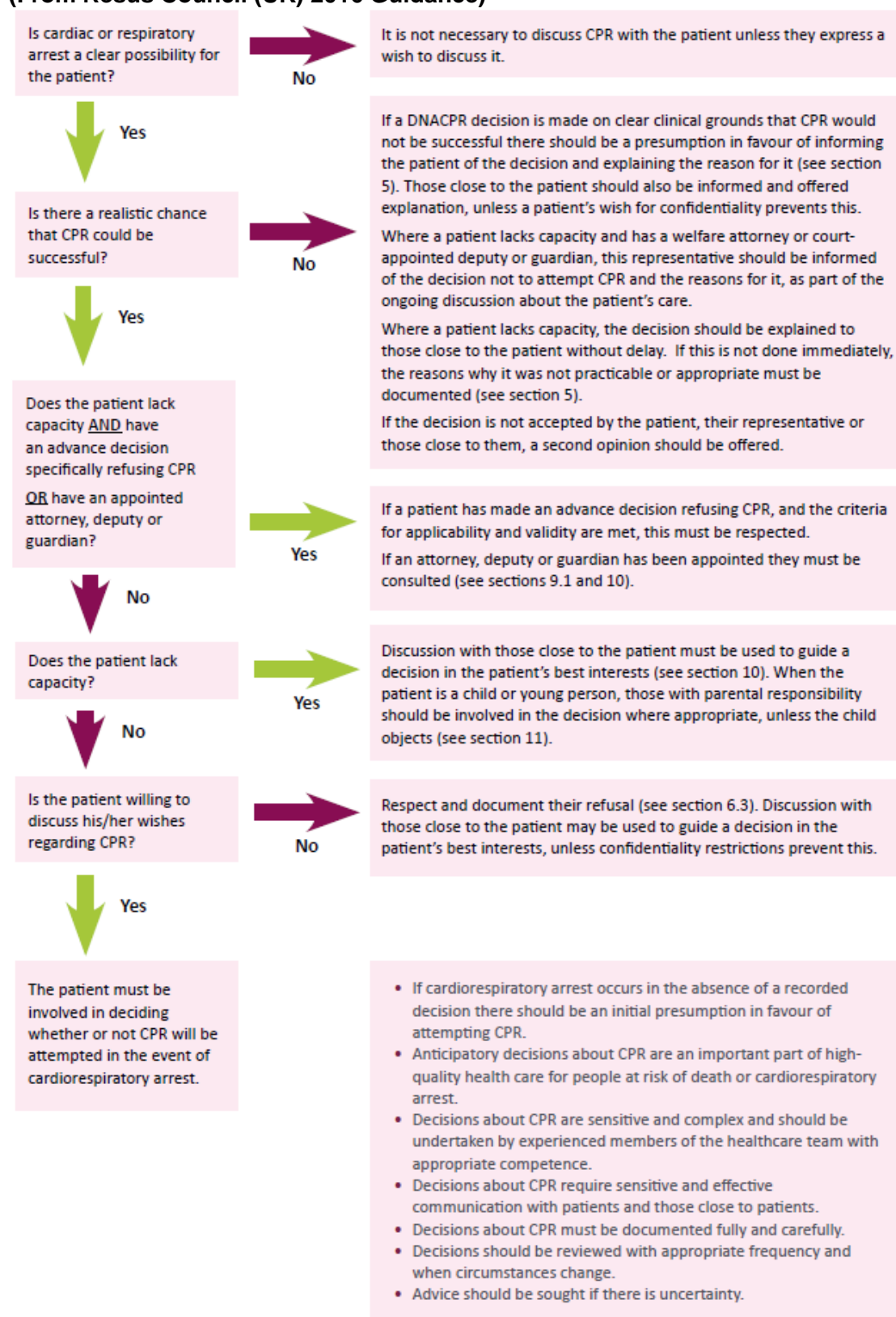
Senior medical staff have a duty to provide parents with adequate information regarding withholding of such treatment and should guide them towards their professional recommendations based on the child's medical and emotional needs.

The decision-making process must be implemented in an atmosphere of open honest communication between parents and senior medical/nursing staff. The clinician must judge the quality of life the child would have to endure if given the proposed treatment and decide whether in all circumstances such a life would be so afflicted as to be intolerable to the child.

The responsibility for decision-making rests solely with the Consultant in charge of the child. Where the parents or patient (if competent) disagree with the Consultant's decision on CPR status then an urgent second opinion should be sought and the matter should be escalated to the Medical Director and Trust Legal Team.

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Appendix A – CPR decision making flowchart (From Resus Council (UK) 2016 Guidance)



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Appendix B – Clinically Agreed Plan form

Patient Details: Name: _____ Date of Birth: _____ Address: _____ Hospital Number: _____ NHS Number: _____	<div style="text-align: right;"> James Paget University Hospitals <small>NHS Foundation Trust</small> </div> <div style="text-align: center; background-color: #00a0e3; color: white; padding: 10px; font-size: 1.2em; font-weight: bold;"> Clinically Agreed Plan (CAP) </div>
ESCALATION AND TREATMENT PLAN	
ACTIVE THERAPIES <input type="checkbox"/> OR COMFORT CARE <input type="checkbox"/>	
<small>State limitations if any (eg. ICU/HDU, NIV, Theatre) Complete Not For CPR section below</small>	
<small>Sign relevant box below. CPR status is valid when signed by a doctor, you do not have to wait for the Consultants signature</small>	
THIS PATIENT IS <u>FOR</u> CARDIOPULMONARY RESUSCITATION Doctor.....Date/Time..... Doctor Signature..... Consultant.....Date/Time.....Sign.....	THIS PATIENT IS <u>NOT FOR</u> CARDIOPULMONARY RESUSCITATION Doctor..... Date/ Time..... Doctor Signature..... Consultant.....Date/Time.....Sign.....
<small>CPR status should be reviewed on each consultants ward round and in response to any change in a patient's condition, or a review requested by a patient or family and as part of discharge planning.</small>	
IF NOT FOR CPR, COMPLETE SECTIONS BELOW	
CPR is: Unlikely to be successful <input type="checkbox"/> Against the patient's wishes <input type="checkbox"/> Not in the patient's best interests <input type="checkbox"/> State Reasoning: _____	
Does the patient have the mental capacity to be involved in communication regarding treatment including CPR? Yes <input type="checkbox"/> No <input type="checkbox"/> If NO complete the 2 stage capacity assessment form on opposite page	
This decision HAS been communicated to the patient? Yes <input type="checkbox"/> No <input type="checkbox"/> (Or Healthcare Power of Attorney if applicable) State date and brief overview of communication: _____ If no communication state date and reasons: (ie: Patient needs more time to think) : _____	
Has this decision been communicated to NOK/Family? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of NOK/Family and brief overview of discussion including date: _____ Family/ NOK not currently available <input type="checkbox"/> state date : _____ If the patient lacks capacity attempts to discuss with relatives or significant others must be made before completing the form. Detail attempts and dates : _____	
<small>If there is a change in CPR status then the CAP form should be marked as VOID, signed and dated, and a new CAP form completed and stapled over the previous form. New forms can be accessed on Intranet.</small>	
<div style="display: flex; justify-content: space-between;"> <small>Version 5 July 2016</small> <small>Page 2 of 2</small> </div>	

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GUIDANCE FOR COMPLETING CAP FORM		
MENTAL CAPACITY ASSESSMENT RECORD FOR COMPLETION OF CLINICALLY AGREED PLAN (CAP) FORM		
STAGE 1		
Does the patient have an impairment of, or disturbance in the functioning of the mind or brain?	Yes	No
(Please give details e.g. stroke, dementia, confusion, significant learning disability, mental disorder, intoxication etc)	<input type="checkbox"/>	<input type="checkbox"/>
If 'No' the patient has capacity to make a decision at this time	<input type="checkbox"/>	
A decision regarding CPR status should be made (using the flowchart below) even if the lack of capacity is believed to be temporary. However the decision should be reviewed with the patient in the event they do regain capacity.		
STAGE 2 (Patient must answer yes to all sections if deemed to have capacity)		
Do you consider the person is able to understand the information relevant to the decision?	Yes	No
Do you consider the person is able to retain the information for long enough to be able to make the right decision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consider the person is able to use or weigh that information as part of the process of making the decision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consider the person is able to communicate their decision?	<input type="checkbox"/>	<input type="checkbox"/>
What help has the person been given to pass the above tests?		
On balance of probabilities the patient does / does not have the capacity to make this decision at this time (delete as necessary)		
Date:.....	Time:.....	
Assessor:.....(print name)	Signature:.....	

This framework can also be used as a guide to good practise in terms of communicating and making any clinically important decisions not just CPR status. Please use in conjunction with the CAP form opposite. If Cardiac Arrest is VERY UNLIKELY during the admission (eg. elective admission for eye surgery) or if Cardiac Arrest is unlikely AND you feel that CPR would definitely be appropriate (eg. young healthy patient admitted with appendicitis) then it is not a legal requirement to discuss CPR with the patient and the default position will be that they are FOR CPR. Tick Active Therapies and complete the "FOR CPR" box. **FOR ALL OTHER ADMISSIONS PLEASE REFER TO THE FLOWCHART BELOW**

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graph TD
    Q1[Could CPR be successful?] -- No --> B1[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. Subject to appropriate respect for the confidentiality those close to the patient should also be informed and offered an explanation.]
    Q1 -- Yes --> Q2[Does the patient lack capacity AND have an advance decision specifically refusing CPR OR have an appointed attorney, deputy or guardian?]
    Q2 -- yes --> B2[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, deputy or guardian has been appointed they should be consulted.]
    Q2 -- No --> Q3[Does the patient lack capacity?]
    Q3 -- Yes --> B3[Discussion with those close to the patient must be used to guide a decision in the patient's best interests. When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate, unless the child objects. Consider the involvement of an IMCA for patients who do not have capacity]
    Q3 -- No --> Q4[Is the patient willing to discuss his/her wishes regarding CPR?]
    Q4 -- No --> B4[Respect and document their wishes. Discussion with those close to the patient may be used to guide a decision in the patient's best interests, unless confidentiality restrictions prevent this.]
    Q4 -- Yes --> B5[The patient must be involved in deciding whether or not CPR will be attempted in the event of cardiorespiratory arrest.]
    
```

If DNACPR order is deemed appropriate to remain in place on discharge:

- Confirm Consultant, patient and/or Next of Kin all in agreement before completing EoE DNACPR form.
- Junior doctors please complete EoE DNACPR form for community use.
- pp the name of the consultant who completed the CAP form if Consultant unavailable to sign.
- Attach a copy of the CAP form to the EoE form

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Appendix C – 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.		 East of England	
Name: <input style="width: 100px;" type="text"/> (OR USE ADDRESSOGRAPH) Address: <input style="width: 100px;" type="text"/> Postcode: <input style="width: 100px;" type="text"/> Date of birth: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> NHS number: <input style="width: 100px;" type="text"/>		ORIGINAL PATIENT COPY TO STAY WITH PATIENT	
Date of DNACPR order: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>			
Reason for DNACPR decision (mark one or more boxes and provide further information) <input type="checkbox"/> CPR is unlikely to be successful [i.e. medically futile] because: <input style="width: 100px;" type="text"/> <hr/> <input type="checkbox"/> Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because: <input style="width: 100px;" type="text"/> <hr/> <input type="checkbox"/> Patient does not want to be resuscitated as evidenced by: <input style="width: 100px;" type="text"/>			
Record of discussion of decision (mark one or more boxes and provide further information) Discussed with the patient / Lasting Power of Attorney [welfare]? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'yes' record content of discussion. If 'no' say why not discussed. <hr/> Discussed with relatives/carers/others? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed. <hr/> Discussed with other members of the health care team? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'yes' record name, role and content of discussion. If 'no' say why not discussed.			
Is DNACPR decision indefinite? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'no' specify review date: <input style="width: 100px;" type="text"/>			
Healthcare professional completing this DNACPR order Name: <input style="width: 100px;" type="text"/> Signature: _____ Position: <input style="width: 100px;" type="text"/> Date: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> Time: <input style="width: 30px;" type="text"/>			
Review and endorsement by responsible senior clinician Name: <input style="width: 100px;" type="text"/> Signature: _____ Position: <input style="width: 100px;" type="text"/> Date: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> Time: <input style="width: 30px;" type="text"/>			

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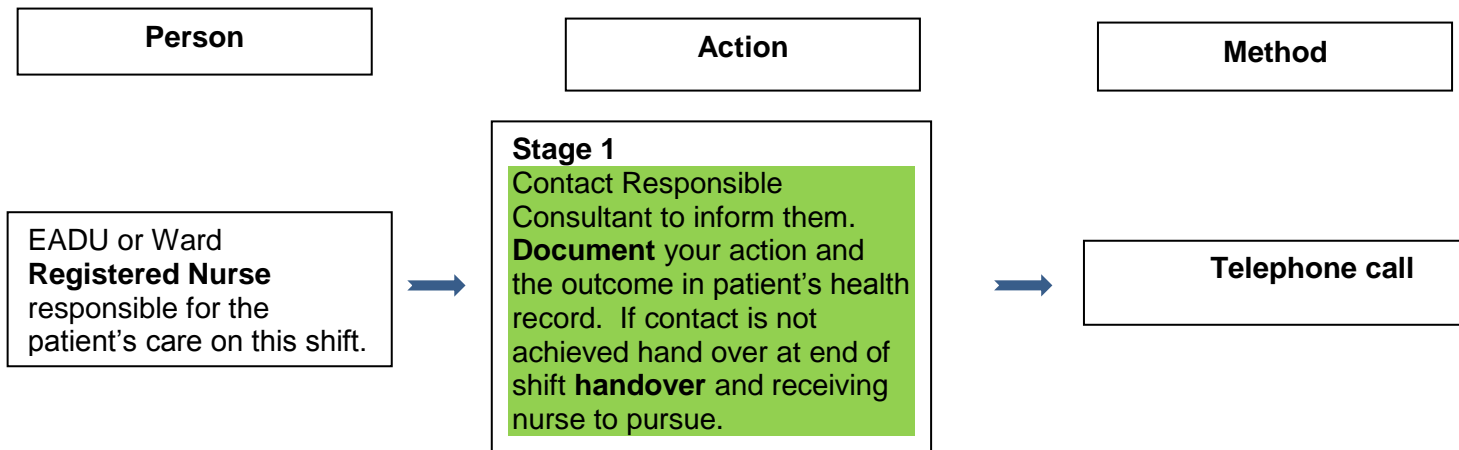
Appendix D – Advance Decision Checklist

Always assume the person has capacity to consent to or refuse treatment. You are required to maximise the person's capacity and facilitate communication.		
QUESTION		ANSWER YES/NO
1.	Does the person have capacity to give consent to or refuse treatment him or herself, with appropriate support where necessary	YES: The person has capacity to make the decision him or herself. The advance decision is not applicable. Ask what s/he wants to do NO: Continue with check list
IS THE ADVANCE DECISION VALID?		
2.	Has the person withdrawn the advance decision? (This can be done verbally or in writing)	YES: This is not a valid advance decision. Make sure that you have identified and recorded the evidence that the person withdrew the advance decision. NO: Continue with check list
3.	Since making the advance decision, has the person created a lasting power of attorney (LPA) giving anybody else the authority to refuse or consent to the treatment in question?	YES: This is not a valid advance decision. The donee(s) of the LPA must give consent to or refuse the treatment. The LPA decision must be in the person's best interests. NO: Continue with check list
4.	Are there reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making the advance decision and which would have affected his/her decision had s/he anticipated them?	YES: If such reasonable grounds exist, this will not be an applicable advance decision. It is important to identify the grounds, discuss this with anybody close to the person, and identify why they would have affected his/her decision had s/he anticipated them, and record your reasoning. NO: Continue with the checklist
5.	Has the person done anything that is clearly inconsistent with the advance decision remaining his/her fixed decision?	YES: This is not a valid advance decision. It is important to identify what the person has done, discuss this with anybody close to the person, explain why this is inconsistent with the advance decision remaining his/her fixed decision, and record your reasons. NO: The advance decision is valid. Continue with the checklist.
IS THE ADVANCE DECISION APPLICABLE?		
6.	(a) Does the advance decision specify which treatment the person wishes to refuse? * (b) Is the treatment in question that specified in the advance decision?	YES: to both (a) and (b): Continue with the checklist NO: This is not an applicable advance decision
7.	If the advance decision has specified circumstances in which it is to apply (see question 3 above), do all of those circumstances exist at the time that the decision whether to refuse treatment needs to be made? (N.B. It is possible for a person to decide that the advance decision should apply in all circumstances)	YES: Continue with the checklist NO: This is not an applicable advance decision

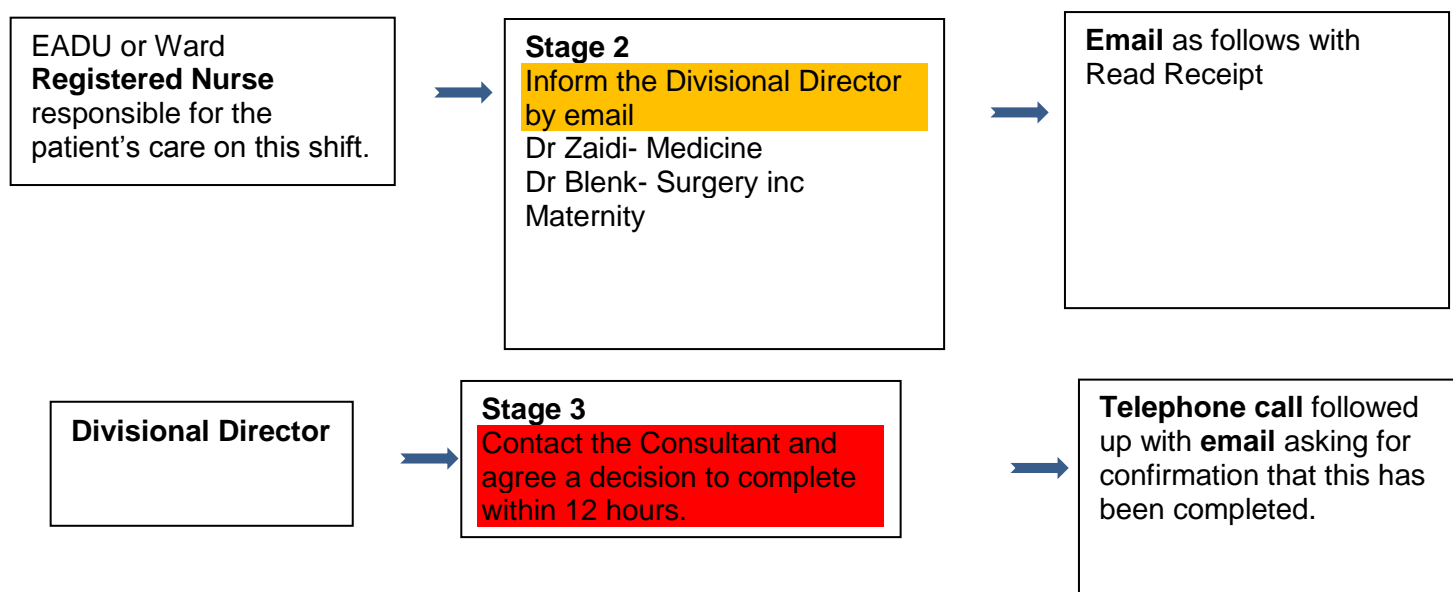
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Appendix E – SOP for Escalation of Incomplete CAP form

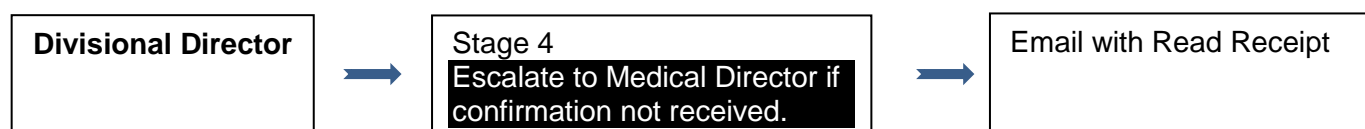
If CAP form is not fully completed within 24 hrs from time of admission



If CAP form is not fully completed within 48 hrs from time of admission



If assurance is not received by the next working day



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Appendix F - Equality Impact Assessment

Policy or function being assessed: Do Not Attempt Cardiopulmonary Resuscitation Policy

Department/Service: Resuscitation

Assessment completed by: Jim Crawford

Date of assessment: 4/8/2016

1.	Describe the aim, objective and purpose of this Policy or function.	The Policy provides guidance on DNACPR decision making for those clinicians involved in discussing, making and implementing such decisions. It also provides information for other staff, patients and those close to patients about the process of making decisions about CPR.			
2i.	Who is intended to benefit from the Policy or function?	Staff X	Patients X	Public X	Organisation X
2ii	How are they likely to benefit?	Patients for whom CPR would not be appropriate will benefit from the guidance to help clinicians make appropriate DNACPR decisions with sensitive consultation with the patient (or those close to the patient) as appropriate.			
2iii	What outcomes are wanted from this Policy or function?	That DNACPR decisions are made appropriately within the Trust and that appropriate discussion of these decisions takes place between the clinical team and the patient (or those close to the patient).			
For Questions 3-11 below, please specify whether the Policy/function does or could have an impact in relation to each of the nine equality strand headings:					
3.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their race/ethnicity ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data	
4.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their gender ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data	
5.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their disability ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data	
6.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their sexual orientation ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data	

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7.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their pregnancy or maternity ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their religion/belief ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their transgender ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their age ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the Policy/function does or could have a detrimental impact on people due to their marriage or civil partnership ?		N	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this Policy/function?			N/A
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.			N/A
14.	Specific Issues Identified			
	None	Page/paragraph/section of Policy/function that the issue relates to		

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15.	Proposals	
	How could the identified detrimental impact be minimised or eradicated?	N/A
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?	N/A
16.	Given this Equality Impact Assessment, does the Policy/function need to be reconsidered/redrafted?	N
17.	Policy/Function Implementation	
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the Policy/function should be adopted by the Trust. Please print: <div style="display: flex; justify-content: space-between;"> <div> Name of Director/Head of Service: Nick Oligbo Date: 19/8/2015 </div> <div> Title: Medical Director </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> Name of Policy/function Author: Jim Crawford Date: 19/8/2015 </div> <div> Title: Resus Committee Chair/A&E Consultant </div> </div> (A paper copy of the EIA which has been signed is available on request).	
18.	Proposed Date for Policy/Function Review	
	Please detail the date for Policy/function review (Yearly): August 2017	
19.	Explain how you plan to publish the result of the assessment? (<i>Completed E.I.A's must be published on the Equality pages of the Trust's website).</i>	
	Standard Trust process	

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20.	<p>The Trust Values</p> <p>In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures.</p> <p>They are that all staff intend to do their best by:</p> <p>Putting patients first, and they will:</p> <ul style="list-style-type: none"> Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. <p>Aiming to get it right, and they will:</p> <ul style="list-style-type: none"> Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services <p>Recognising that everyone counts, and they will:</p> <ul style="list-style-type: none"> Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. <p>Doing everything openly and honestly, and they will:</p> <ul style="list-style-type: none"> Be clear about what they are trying to achieve, Share information appropriately and effectively, Admit to and learn from mistakes. <p>I confirm that this Policy/function does not conflict with these values. <input checked="" type="checkbox"/></p>
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