Cheshire and Merseyside
Strategic Clinical Networks

Unified DNACPR Adult Policy Toolkit

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Contents

Aim of the toolkit

To support localities in a robust implementation process for a unified DNACPR Adult Policy by providing guidance and resources. These resources have been developed and shared by localities across Cheshire and Merseyside Strategic Clinical Network.

Grateful thanks to Dr Kate Marley, Consultant in Palliative Medicine, Warrington and Halton Hospitals NHS Foundation Trust; Kelly Jones, Project Manager, Liverpool CCG; Jan Cummins, Team Coordinator, Integrated Advance Care Planning Service, Knowsley and Kath Davies, Network Assistant, Cheshire and Merseyside Strategic Clinical Network.

Introduction

The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, then that treatment is no longer justified (BMA, RC (UK), RCN 2007).

Although cardiopulmonary resuscitation (CPR) can be attempted on any person prior to death, the chance of survival following CPR in adults is relatively low depending on the circumstances. There comes a time for some people when it is not in their best interests to aggressively treat in this manner. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity.

Throughout England, and at regional and local level, work is happening in relation to improving patient experience and organisational working around DNACPR.

DNACPR has been identified as a regional priority across the North West with agreement to have common principles around DNACPR. Implementing a unified policy would ensure a more robust and consistent approach towards End of Life Care and allowing a natural death, where appropriate, for patients living in the North West. This would:

- Ensure patient and carer views are sought and that choice around end of life is identified and the information shared
- Support people to die in their preferred place of death if that is their wish
- Reduce the numbers of people at the end of life being unnecessarily admitted to hospital
- Improve patient, carer and family experience of end of life care by reducing inappropriate admission to hospitals
- Promote a single patient held form which is easily identified to minimise risk to patients

- Ensure patients are confident that health and social care professionals in the North West will be operating to the same DNACPR principles and practice
- Standardise documentation to reduce the high degree of variance for health and social care professionals, including ambulance personnel
- Increase policy integration between care settings and services

Benefits of a unified policy

The aim of the unified policy is to ensure patients have a seamless service across settings and localities. Improving the patient and relatives experience is paramount and will also support the professional in the delivery of care.

- Reduction of inappropriate emergency admissions
- Reduction in length of stay and timely discharge of those at the end of life in accordance with patient choice
- Effective transfer of information, streamlined across settings including rapid response services, hospice at home, social care and hospices 24/7
- Reduce repeated conversations about DNACPR in multiple settings
- Transparency
- Increased assurance of the safety of patients
- Increased numbers of staff who will be better trained to respond to the principles of the DNACPR policy
- Potential reduction in the number of complaints
- Reduction of inappropriate emergency ambulance call outs

Implementation of the Unified DNACPR Adult Policy

Points to consider

- Is your organisation agreeable to adopt the principles?
- Is your organisation agreeable to adopt the unified policy from North West Ambulance Service (NWAS)? *originally adapted from South Central SHA*
- Is your organisation agreeable to adopt the DNACPR form agreed by the NWAS Steering Group?
- Is there a willingness and agreement across the locality in all settings including acute, community, care homes, hospice, prisons and tertiary centres?
- Who will Chair a working group which includes representation from each setting?
- Consider what support may be required for the significant changes needed within organisations to achieve workable solutions
- Financial considerations, e.g. cost of pads and leaflets
- Education
- Audit
- Informing the Coroner that the policy is to be implemented

Challenges

- Promoting the policy to decision makers and other Health and Social Care Professionals
- Ensuring that there is a continued focus on the improved quality of care for patients
- Ensuring continued commitment to achieving a unified DNACPR policy and a single, patient held form
- Ensuring all settings are engaged with and committed to the process
- Where an organisation is not adopting the policy, how will other organisations work with this

Potential membership of locality steering group for Unified DNACPR Policy

This is a significant piece of work that will involve change for many organisations that have already developed policies. A lead should be nominated from each organisation as a point of contact to engage in this process and support work to unify principles and documentation around DNACPR. It is important to engage with all sectors and settings including 3rd sector, social care and voluntary organisations.

Commissioner

To seek involvement from health and social care to facilitate agreement in relation to adoption of the work that the "task and finish" group agree on.

Lead Clinician Role

The lead clinician will represent their wider organisation in terms of the work to be undertaken and facilitating implementation within their organisation.

Other Representation

Representative from each setting; acute hospital, CCG, community trust, care homes, hospices and tertiary centres.

ResuscitationTeam

Ensure that existing resuscitation groups are aware of the process and will be actively involved in the adoption and subsequent implementation process.

Social Care Representation

Should represent the wider organisation e.g. local authority, in terms of the work to be undertaken and facilitating implementation with wider stakeholders within social care.

Patient/Carer Representative

Consider representation from Health and Wellbeing Board or Health Watch.

Mental Health Representative

This could be a representative from a mental health trust and IMCA.

Secure Offender Services

Consider representation from any prisons within the locality.

Safeguarding Representation

Consider identifying a lead from the Safeguarding Adults Team.

Case Study: Implementation of the NWAS Adult uDNACPR Policy in Warrington

Warrington worked together as a whole locality to ensure adoption and ratification of the policy was consistent across the area. It was decided that the policy would be launched in October 2013 in all health care settings in the locality.

The local steering group had representation from:

- Specialist Palliative Care Consultant representing the community and hospice
- A community clinical nurse specialist in Palliative Care
- End of Life Care Facilitator for Care Homes
- General Practice – local GP CCG lead for Palliative and End of Life Care
- District Nursing Manager
- Hospital – Consultant lead for resuscitation
- Representatives from other organisations were invited as needed

The steering group developed the core content of the education and method of delivery. Members of the group who were delivering the education attended the initial presentations to ensure the delivery and content was consistent.

The first education sessions were delivered in the form of 1 hour presentations by the group members leading on the education with the following content:

GMC/National Council Guidance	**15 minutes**
New forms, cancelling the form and audit plans	5 minutes
• **Practical applications:** • **Making the decision** • **Having the discussion** • **What if they refuse?**	 10 minutes 10 minutes 5 minutes
Discussion	15 minutes

To facilitate choice and opportunity the presentation was delivered at different times of the day (morning, lunch time and afternoon) and on different days of the week.

Invitations were sent to:

- GPs
- Hospice doctors
- Hospice senior nurses
- Prison doctors
- Out of hours GPs
- The local mental health trust doctors
- Care home managers
- District nursing team leaders
- Social care managers
- Community Palliative Care Nurse Specialists
- The Consultant resuscitation lead and resuscitation officers from the acute trust

There was a further delivery of the presentation to local GPs at a Protected Learning Time (PLT) event.

In the hospital the Resuscitation department led the roll-out of the policy as the group felt that in the hospital as in this setting the issue of DNACPR touches a wider population than those in the 'end of life' category and so Palliative Care would not be the optimum lead specialty for this project. The consultant lead for Resuscitation attended departmental audit meetings and delivered presentations at departmental education meetings and the grand round. Drop-in sessions for clinicians were provided and there were safety alerts sent out across the trust email system as well as information on the intranet. The DNACPR policy is taught on the life support updates that staff members have in the hospital also.

Ongoing education is planned to reinforce the messages from the original teaching and address any issues which have come up from the initial use of the new documentation.

Education

The development of this toolkit of resources can be adapted and utilised within each locality to reduce variation and ensure:

- An educated, confident and competent workforce to deliver care in line with individual patient needs
- Promote consistency across the network
- Influence staff behaviour and increase the number of staff offering a discussion about end of life care with patients and families ensuring patients receive appropriate, timely care at the end of their life
- Improve the patient and family experience and their memories after death
- Ensure the wishes of the patient and family are discussed and documented across the patient pathway for DNACPR decisions in a consistent format

It is important that education sessions meet the needs of the target audience:

- Group 1: For Decision Makers
  Staff who have direct DNACPR discussions with patients or their representative and are the decision makers who complete the form
- Group 2: Raising Awareness Sessions
  Health and social care professionals who have direct contact with patients who may have a DNACPR order in place

Each institution/organisation needs to identify the eligible staff who meets the criteria for inclusion onto the relevant educational event which should include:

- Doctors
- Nurses
- Allied Health Professionals
- Care Home Staff
- Domiciliary Care Staff
- Social Workers
- Mental Health Trusts
- Prison Staff
- Dentists
- Pharmacists

Resources to support implementation of the uDNACPR Policy

The following resources have been collectively sourced, developed and agreed across the Network from various localities. Permission is given for organisations delivering the programme to include own logos and local information.

To access the resources visit the Cheshire & Merseyside SCN website on www.cmscnsenate.nhs.uk. Hard copies are included in the relevant appendices:

Appendix

A	Unified Adult DNACPR Policy presentation	**A. Unified Adult DNACPR Policy (PowerPoint)**
B	Care Home PowerPoint presentation	**B. Care Homes DNACPR (PowerPoint)**
C	Guidance for care homes flyer	**C. Guidance for Care Homes Flyer**
D	DNACPR Conversations Flowchart	**D. DNACPR Flow Charts (PDF)**
E	Decision Making Framework	**E. Decision Making Framework (PDF)**
F	Mental Capacity Act 2005 Guidance	**F. MCA 2005 Guidance (PDF)**
G	Frequently Asked Questions	**G. DNACPR FAQ (word document)**
H	How to Complete the DNACPR form PowerPoint presentation	**H. DNACPR – how to complete the form (PowerPoint)**
I	e-ELCA Curriculum Access at: http://www.e-lfh.org.uk/projects/end-of-life-care/ Training Needs Analysis http://portal.e-lfh.org.uk/Component/Details/404448	**I. e-ELCA (PDF)**

Other useful resources

ADRT:
http://www.adrt.nhs.uk/index.html
Dying Matters Website:
http://www.dyingmatters.org/overview/resources
York and Humber DNACPR Training Webcast:
http://nww.nyypct.nhs.uk/HR/WD/DNACPR/index.htm
Resuscitation Council:
http://www.resus.org.uk/Index.html
Why Make DNACPR Decisions:
http://www.youtube.com/watch?v=N4hUSRgoI1A&feature=youtu.be
DNACPR Cultural Differences:
http://www.youtube.com/watch?v=YIBIgIckzDg&feature=youtu.be
CPR and End of lIfe Care Planning:
http://www.youtube.com/watch?v=GZ8UwVKHa58&feature=youtu.be
CPR Success Rates:
http://www.youtube.com/watch?v=y3zfQFmnMO8&feature=youtu.be
DNACPR – good communication:
http://www.youtube.com/watch?v=K0UNCXMZlBM&feature=youtu.be
DNACPR Forms:
http://www.youtube.com/watch?v=fKtDNT_t0Pc&feature=youtu.be
Best Interests:
http://www.youtube.com/watch?v=mFLvoX_ngfM&feature=youtu.be
Other factors affecting decisions:
http://www.youtube.com/watch?v=iY0Ol5G3oCo&feature=youtu.be
Advance Decision to Refuse Treatment:
http://www.youtube.com/watch?v=Hl56yJrgSWI&feature=youtu.be
Mental Capacity:
http://www.youtube.com/watch?v=eHDbE3hW2P0
If the above links do not work please copy and paste the web address into your internet browser.

NWAS Documentation

Each locality should make reference to their local policy. The three forms below are the agreed DNACPR documents. The lilac copy is the patient held document, which should transfer with the patient across settings. There are two formats available, electronic and paper, which if printed MUST be printed on lilac paper for the patient held copy. Two further white copies are for audit purposes and case notes.

Appendix

J **Electronic version of the uDNACPR form**
http://www.nwas.nhs.uk/health-professionals/end-of-life-care/udnacpr/

J. Electronic uDNACPR Form (PDF)

It is up to each locality to procure their own supply of pads and leaflets and individual organisations to be aware of the ordering process for further resources.

Patient Information Resources

Appendix		
K	Patient information booklet	K. Patient Information Leaflet (PDF)
L	Example of an easy read patient information booklet	L. Decisions about easy read CPR (PDF)

Further Information

M	uDNACPR NWAS Update for staff	M. uDNACPR NWAS update
N	ERISS is the North West Ambulance Service's Electronic Referral & Information Sharing IT System that will inform NWAS if a patient at an address has a DNACPR decision in place. It is a web based system and can be registered with and logged into by individual organisations by an individual e.g. The GP. Once their registration is set up the individual can enter patient details into the system, which in turn will flag up to NWAS that a DNACPR decision is in place at that address. Register at: **www.eriss.nhs.uk**	N. ERISS Leaflet (PDF)

Audit

There is an audit tool included within the policy.

O	Audit Tool	O. Audit Tool (word document)

Appendices

Appendix A

Unified Adult DNACPR Policy

Acknowledgement to Warrington Implementation Team

Then

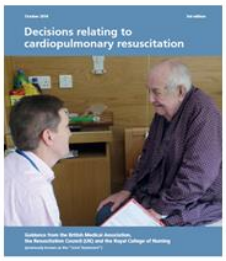
- Defibrillation (attempting to re-set the heart rhythm with a DC electrical shock) was first used to re-start a human heart in 1947.
- Alongside other elements of CPR, it has been a standard part of coronary care and cardiac surgical practice since the 1960s.
- Initially patients were selected to have this new treatment

Now

- The default position is to attempt CPR in the event of a cardiac arrest unless there is an advance decision not to.

UK Resuscitation Council Guidance

- The revised guidance was published in 2014
- Survival from CPR is relatively low:
  - Chances of survival to hospital discharge is 15-20%
  - Chances in out of hospital arrest is 5-10%
- Post arrest most patients will require HDU/ITU/CCU
- CPR is not risk free



UK Resuscitation Council Guidance

- There is no legal/ethical requirement to discuss every eventuality with patients if risk of cardiac arrest is low
- If there is an identifiable risk of arrest it is desirable to make decisions regarding CPR
- Making decisions early is preferable to making them in a crisis situation

Non-Discrimination

- Decisions should be tailored to individual circumstances of patient
- **'Blanket policies to deny CPR to whole groups are unethical and probably unlawful'**
- Decisions must be made objectively
- If there is no explicit decision about CPR the presumption should be to perform CPR in the event of a cardiac arrest

Decisions relating to CPR UK Resuscitation Council 2014

DNACPR Decisions

- Where the team is as sure as it can be that CPR would be unlikely to restart the heart and breathing, CPR should not be offered.
- A DNACPR in itself is not legally binding and may be overridden by professionals if circumstances of a cardio respiratory arrest do not match the circumstances envisaged when making the initial DNACPR order e.g. in patients with a DNACPR order, it may be appropriate to suspend that decision temporarily e.g.
  - Blocked tracheostomy
  - During certain procedures
- Need to discuss with patient so they are aware that the decision can be suspended in these situations

Decisions relating to CPR UK Resuscitation Council 2014

Communicating DNACPR decision to patients

- There should be a presumption in favour of informing the patient of a DNACPR decision
- There needs to be convincing reasons not to inform the patient i.e. where the clinician considers that to do so is likely to cause the patient physical or psychological harm
- There should be clear and accurate communication with the patient and those close to the patient unless the patient has requested confidentiality

Decisions relating to CPR UK Resuscitation Council 2014

Weighing up benefits and burdens

- Where CPR may result in return of spontaneous breathing and circulation but may be followed by a length and quality of life unacceptable to the patient
- Patient ideally part of decision making process if they wish to participate in discussions
- Decisions should be made in the best interests of the patient
  - Likely outcome
  - Patient's human rights
  - Likelihood of having severe pain and suffering
  - Level of awareness patient has of their surroundings
- MDT discussion

Decisions relating to CPR UK Resuscitation Council 2007

Where patients lack capacity

- Consider any previously expressed wishes
- Check whether patient has an LPA (lasting power of attorney)
- Discussion and agreement between the healthcare team and those close to or representing the patient (unless a patient had previously expressed a wish that information is withheld

Consulting with those close to patients is not only good practice but a requirement of the Human Rights Act (Article 8)

- Communication should be done by experienced members of the team

Decisions relating to CPR UK Resuscitation Council 2014

Documentation of CPR Decisions

- **Decisions should be accessible to all healthcare professionals who may need them**
- **Any decisions relating to CPR should be communicated between healthcare professionals when patients move between settings**
- Overall responsibility for DNAR decision rests with the most senior healthcare professional responsible for the patient's care

Decisions relating to CPR UK Resuscitation Council 2007

GMC Guidance

- Published 2010
- DNACPR seen as good practice for ensuring that people who are dying have a peaceful dignified death.
- Seen as part of good advance care planning

GMC Guidance

- In cases in which CPR might be successful, it might still not be seen as clinically appropriate because of the likely clinical outcomes:
  - Weigh up the benefits, burdens and risks of treatment that the patient may need if CPR is successful.
  - In cases where you assess that such treatment is unlikely to be clinically appropriate, you may conclude that CPR should not be attempted

- 'You must approach discussions sensitively and bear in mind that some patients, or those close to them, may have concerns that decisions not to attempt CPR might be influenced by poorly informed or unfounded assumptions about the impact of disability or advanced age on the patient's quality of life.'

Decisions about CPR at End of Life

- Don't make assumptions about patients' wishes
- Some patients may find discussions about this very burdensome and some may want the discussion.
- You should not withhold information simply because conveying it is difficult or uncomfortable for you or the healthcare team.

- If you conclude that the patient does not wish to know about or discuss a DNACPR decision, you should seek their agreement to share with those close to them, with carers and with others, the information they may need to know in order to support the patient's treatment and care.
- If a patient lacks capacity, you should inform any legal proxy and others close to the patient about the DNACPR decision and the reasons for it.

Where CPR may be successful

- If CPR may be successful, the benefits of prolonging life must be weighed against the potential burdens and risks.
- The patient should be involved in the discussion if they want to and this should be done sensitively
- You should explain any doubts about whether the burdens and risks of CPR would outweigh the benefits, including whether the level of recovery expected after successful CPR would be acceptable to the patient.
- Some patients may wish to receive CPR where there is no/little chance of success. '**If, after discussion, you still consider that CPR would not be clinically appropriate, you are not obliged to agree to attempt it in the circumstances envisaged.**'
- You should explain your reasons and any other options that may be available to the patient, including seeking a second opinion.

Patients who Lack Capacity

- If a patient lacks capacity to make a decision about future CPR, consult any legal proxy who has authority to make the decision
- If there is no legal proxy, discuss the issue with those close to the patient and with the healthcare team.
- If they do not have legal authority to make the decision, you must not give them the impression that it is their responsibility to decide whether CPR will be of overall benefit to the patient.
- If the legal proxy requests that CPR with a small chance of success in spite of the burdens and risks, or they are sure that this is what the patient wanted, and it is your considered judgement that CPR would not be clinically appropriate and not of overall benefit for the patient, you should explore the reasons for the proxy's request.
- If after further discussion you still consider that attempting CPR would not be of overall benefit for the patient, **you are not obliged to offer to attempt CPR in the circumstances envisaged.** You should explain your reasons and any other options that may be available to the legal proxy, including their right to seek a second opinion.

Treatment and Care after a DNACPR Order

- Make it clear that a DNACPR decision applies only to CPR. It does not imply that other treatments will be withdrawn or withheld.
- Can reverse the DNACPR in certain circumstances e.g. choking, on induction of anaesthesia

NWAS Integrated DNACPR Policy

- Why do we need one?

Bob

- Bob was a 78 year old gentleman with metastatic bowel cancer.
- His wish had been to die at home and the GP, district nurses and community palliative care nurses knew of this.
- He was becoming increasingly frail and bed bound and his family were told that time was short.
- One morning whilst his daughter was taking the children round the corner to school, Bob stopped breathing.
- His wife had been very anxious all the way through Bob's illness and panicked. She called 999 as she could not remember the advice given by the GP

Bob

- The ambulance was there in no time at all. The paramedics had been briefed that there was a patient in respiratory arrest in the house and they started CPR and insisted on taking Bob to hospital. Bob's daughter arrived home to see the ambulance leaving and her mum distraught on the front path.
- The CPR was stopped very soon after arrival in the Emergency department as the hospital notes were accessible.
- Bob's wife and daughter got to the hospital after it was all over but had to wait for someone to come and speak with them and also for the police to come.

New Form

- This decision will be regarded as "ONGOING" unless:
  - There are changes in the person's condition
  - Their expressed wishes change
- DNACPR decisions should be subject to ongoing monitoring to ensure they remain appropriate
- It is recommended that a review date be considered and entered on the DNACPR decision form if appropriate.
- It is important to note that a review date does not equate to an expiry date for ongoing decisions and remains clinically appropriate and valid.
- The basis on which decision has been made and what conversations have occurred about it should be recorded
- The lilac copy of the form stays with the person
- One white copy remains in the medical notes
- One white copy is retained for audit purposes

Using the Form

- There are packs of the triplicate forms in all areas.
- There is an electronic version of the form which **must** be printed on lilac paper
- The lilac form travels with the patient between home/hospital/hospice
- There should also be documentation in the patient's notes that the DNACPR order has been made

Setting Specific Info

- The lilac form is placed in their home
- A white copy remains in their notes at the GP's surgery
- Also make a note in the records
- The third white copy is retained for audit purposes.
- There is a tear off slip for the message in a bottle scheme if this is active in your area

In the patient's home

- The triplicate form stays together in the front of the person's notes until death or discharge. On discharge (from the care setting instigating the form):
  - The lilac copy of the form stays with the person
  - One white copy remains in the medical notes and;
  - One white copy is retained for audit purposes

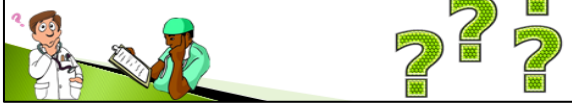
In an inpatient setting (hospital/hospice/nursing home/prison)

Cancelling the decision

- If the decision is cancelled, the form should be crossed through with two diagonal lines in black ink and the word 'CANCELLED' written clearly between them, dated, signed and name printed by the health care staff.
- Retain the cancelled form in the person's notes.
- It is the responsibility of the person cancelling the decision to communicate this to all parties informed of the original decision.

Making the Decision

- There are several factors to be considered:
  - Would CPR realistically have a chance of restarting the heart and breathing?
  - Would the patient be accepted for care to CCU/ITU?
  - Is CPR an appropriate treatment to offer?
  - What are the patient's wishes?
  - Would the patient be harmed by having discussions around CPR?



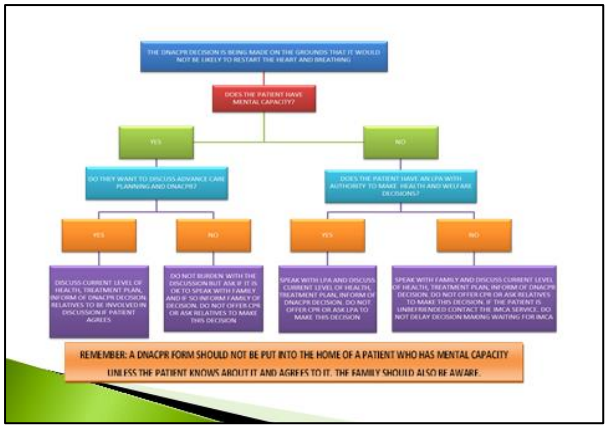
For patients who lack capacity

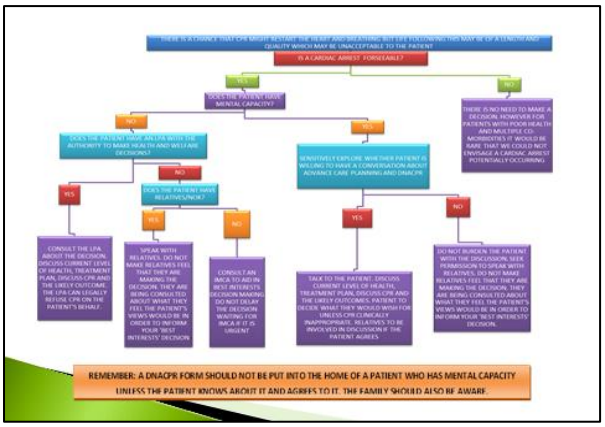
- If the decision is a straightforward clinical one on the grounds that it would be unsuccessful then make the DNACPR decision and speak to those close to the patient
- If there is a chance CPR will work but there are other factors which mean a competent patient might refuse then a best interests decision should be made informed by the MDT and the views of those close to the patient about what the patient's wishes might have been
- Relatives or LPAs with authority to make health and welfare decisions do not have the right to demand clinically inappropriate treatment.
- Where a patient has no relatives an IMCA should be contacted. This should not delay the decision however

Having the Discussion

'Don't ask me about resuscitation for him. They asked me that about me mother 10 years ago and I've felt ever since like I killed her'

'I'm not ready to die yet so don't be talking to me about that'





General Principles

- Start with what you are going to do not what you're not
- In the majority of cases it is 'breaking bad news'
- Remember saying 'to resuscitate' implies that it can be done/will work
- Don't offer it as an option if there is no chance it will work.
- Don't pose it as the relatives' decision – it is not (unless they are an LPA with authority to make health and welfare decisions. Even then they can only refuse it not demand it)

Do ✓ | Don't ✗

When to discuss with patients

- DNACPR decisions should be discussed with patients unless there is a risk of significant harm coming to them by having the conversation.
- If a person is to have a DNACPR form in their house and they are able to access their District Nursing notes they should know about the decision
- Avoid having the conversation on the day of discharge if a form needs to go home with the person
- If someone is deteriorating rapidly and likely to die imminently it may not be appropriate to have that conversation with them and will change the focus of the discussions to have with the family
- If a patient indicates that they do not wish to have the conversation then it should not be forced upon them

What to say

- Need to emphasize what the decision means: treatment for all the reversible things we can but if it doesn't work and the heart stops then there isn't anything we could do to restart it
- Still would get treatment in hospital if needed.
- Does not have a bearing on chemotherapy etc.
- Patients/relatives need to know that they should bring the form with them to hospital/the hospice/if they are going into a respite/rehab/long term nursing care facility.
- They should alert visiting health professionals/paramedics to the whereabouts of the form in their home if needed.

What if they refuse?

- No-one can demand a clinically inappropriate treatment
- Disagreements should hopefully be rare if the discussion is approached sensitively
- Always aim for consensus, case conferences, mediation etc.
- A second senior doctor (consultant or GP) opinion should be sought.
- Involvement of organisational legal department may be necessary
- Ultimately a patient cannot be forced to have a DNACPR form in their house if they don't want one

Discussion

Further Reading

- https://www.resus.org.uk/pages/dnacpr.htm
- www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp
- www.adrt.nhs.uk
- www.nwas.nhs.uk/health-professionals/end-of-life-care/udnacpr/
- Time to intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiopulmonary arrest National Confidential Enquiry into Patient Outcome and Death 2012

Appendix B

CARE HOMES

The North West Unified Do Not Attempt Cardio-Pulmonary Resusitation Policy

Presented by:
Date:
Acknowledgement to Knowsley ACP Team

- Cardiopulmonary resuscitation (CPR) is an emergency procedure which may include chest compressions and ventilations in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation Council (UK) guidelines.

- Cardiac arrest is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal gasping respiration.

- Respiratory arrest is the cessation of normal respiration due to failure of the lungs to contract effectively.

Survival Rates

- Public believe success rate is high and that having CPR carries no risk
- Survival rate where the patient has multiple health problems is 0.3%
- Survival from CPR is relatively low:
  - Where the cardio respiratory arrest occurs in hopsital the chances of survival to hospital discharge is 15-20%
  - Where the cardiac arrest happens outside the hospital the chances of surviving to hospital discharge is 5-10%

All people are presumed to be "for CPR" unless:

- A valid DNACPR decision has been made and documented or;
- A valid and applicable Advance Decision to Refuse Treatment (ADRT) prohibits CPR.

- Advance Decision to Refuse Treatment
- It is a general principle of law and medical practice that people have a right to consent to or refuse treatment. Even if it results in their death.

- The policy will provide a framework to ensure that DNACPR decisions:
- Respect the wishes of the individual, where possible
- Reflect the best interest of the individual
- Provide benefits which are not outweighed by burden.

- Patients / carers do not have the right to demand medically futile treatments
- Patients / Carers should be informed in decision-making
- Preferable to emphasise end-of-life care when expected part of the dying process

- CPR unlikely to be successful
- Burdens outweigh the benefits
- We know when CPR would be successful or not – when should we discuss it?

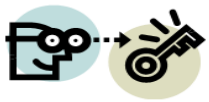
- When cardiac/ respiratory arrest likely to occur due to terminal disease/ multiple co-morbidities
- After successful but inappropriate CPR attempt
- Patient choice

- Applicable to all individuals aged 18 and over
- Is part of Advance Care Planning for patients and should work in conjunction with end of life planning for individuals

- This policy must only be used by individuals who are trained and competent in the application of the Mental Capacity Act (2005) and in full accordance with organisational MCA policy and related guidance or procedures.

Responsibility of Staff

- Health and social care staff are expected to understand how the MCA works in practice and the implications for each patient for whom a DNACPR decision has been made.



Responsibilities of Staff (cont.)

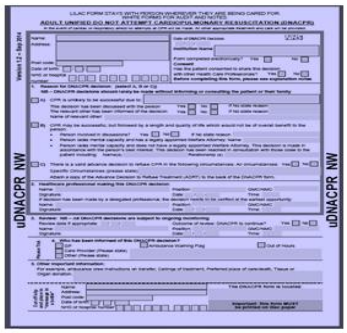
- Adhere to the policy and procedure
- Notify their line manager of any training needs
- Sensitively enquire as to the existence of a DNACPR or an ADRT
- Check the validity of any decision
- Notify other services of the DNACPR or an ADRT on the transfer of a person
- Ensure uDNACPR form is always with the person when they are away from the care home.
- Participate in the audit process

Responsibility of decision maker

- Be competent to make the decision
- Ensure the decision is documented
- Involve the individual following best practice guidelines when making a decision and if appropriate involve others in the discussion
- If the person lacks capacity and has no LPA or IMCA if the person is unbefriended, consult with those close to the them and document name and relationship to person.
- Communicate the decision to other health and social care providers
- All DNACPR decisions are subject to ongoing monitoring.

- DNACPR decision only needs to be made once.
- DNACPR decision is transferred from one setting to another.
- Decision can be reviewed, can be indefinite or can be revoked

A4 **Lilac** Form (2 white carbonated copies)



- The lilac copy of the form stays with the patient in the care home
- One white copy remains in the medical notes
- One white copy is retained for audit purposes

- All DNACPR decisions are subject to ongoing monitoring
  - A review date can be specified if appropriate. A review date does not mean the decision expires- rather the clinician responsible for the decision should check the decision to make sure it is appropriate

- Ask GP (not an OOH GP) to visit to discuss DNACPR with resident/family or;
- Ask GP to attend Best Interest meeting to discuss DNACPR (use IMCA if needed)
- Completed lilac form is kept in a place where **all** staff can access it day or night.
- Ensure **all** staff are aware of which residents have a DNACPR and where the forms are kept.

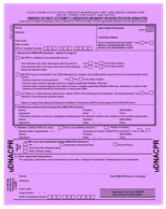
- Ensure the lilac form goes with the patient
- The lilac form will be kept in the hospital for the length of admission.
- The lilac form will be sent home with the patient on discharge.
- File the lilac form in its usual place when the resident returns to your home.
- Ensure all staff are aware of DNACPR status of resident and has access to the form.

- Ensure that the lilac form goes with the resident whenever they go out of the home.
- Ensure DNACPR status is communicated to ambulance personnel
- Remember DNACPR is only applicable when the form can be seen.

- This lilac form will replace all existing DNACPR orders.
- There is an agreed 3 month* transition period to transfer all existing DNACPR orders. **Insert locally agreed dates**

*Modify timeframe as appropriate

- Be proactive: ask GP to transfer to new lilac form at next visit
- GP needs to register the DNACPR order with the ambulance service – through ERISS



- Discuss with your organisations owner/manager
- Feedback information from today to ***all*** staff in your care homes.
- Decide on a place where all completed DNACPR forms will be kept and ensure ***all*** staff are aware.
- Ensure ***all*** staff are aware when a patient has a DNACPR form completed.

- Discuss with your organisations owner/manager
- Feedback information from today to ***all*** staff in your care homes.
- Decide on a place where all completed DNACPR forms will be kept and ensure ***all*** staff are aware.
- Ensure ***all*** staff are aware when a patient has a DNACPR form completed.

- Transitional period – insert locally agreed dates
- Ensure all existing forms are transferred to new documentation within this time period.
- GPs to start using lilac forms for all new patients

Thank You

ANY QUESTIONS

For further information please contact;
Insert Local Details

Appendix C

NORTH WEST UNIFIED DNACPR POLICY

IMPORTANT INFORMATION FOR CARE HOME STAFF

Insert Own Logo

The North West Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy has been adopted across Cheshire & Merseyside and will be implemented in your area in February 2014

The Unified DNACPR Policy has been adopted as part of the Advance Care Planning process which supports residents to achieve their wishes and preferences for their end of life care.

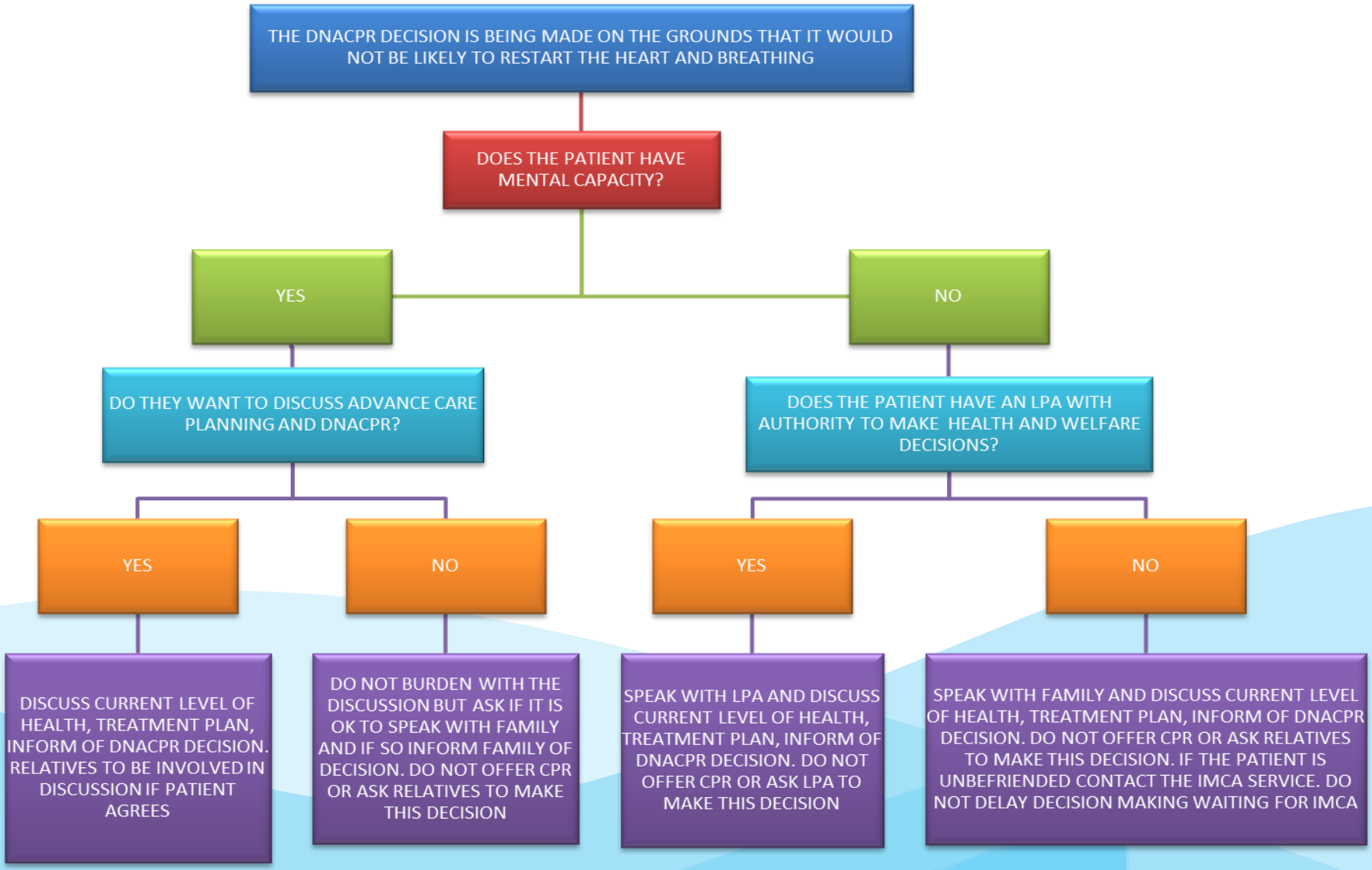
- GPs, following discussions with the patient and/or relatives will make a medical decision the resident is not for CPR and complete a LILAC FORM. This will be left in the care home.
- If the resident is admitted to hospital or hospice the form must go with the resident.
- If the resident has an inpatient episode and a DNACPR decision is made, a lilac form will be transferred with the patient back to the care home.
- The form is transferable between settings and does not need to be rewritten by the GP on the residents return
- If residents already have a DNACPR form in place ask the GP to update to the unified lilac form at next visit (unless review date is due to expire). DNACPR forms in place will still be valid until INSERT LOCALLY AGREED DATE HERE

Please ensure all your staff are aware of this new policy and display prominently

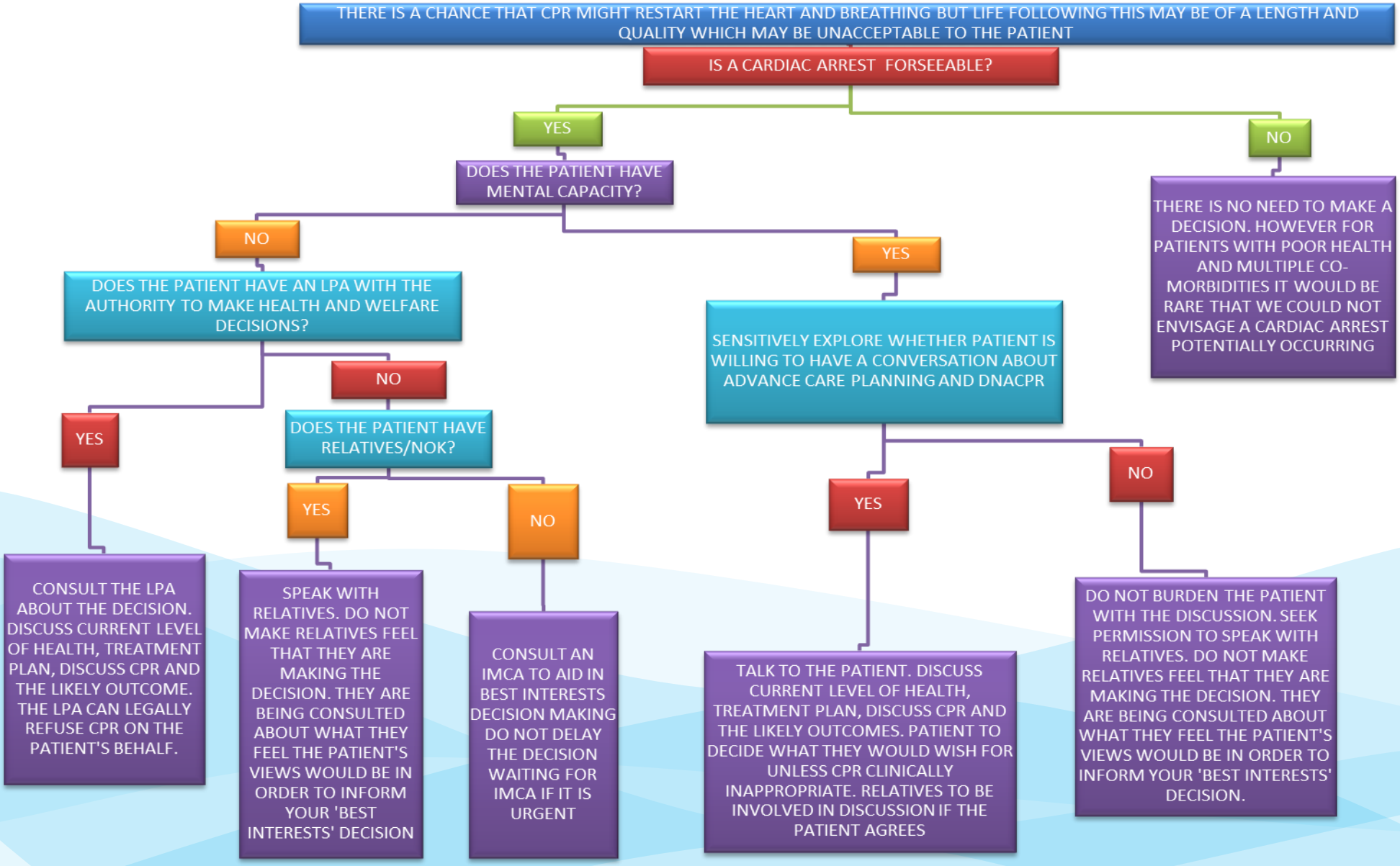
For further information please contact:
INSERT LOCAL DETAILS HERE

Jan 2014

Appendix D



REMEMBER: A DNACPR FORM SHOULD NOT BE PUT INTO THE HOME OF A PATIENT WHO HAS MENTAL CAPACITY UNLESS THE PATIENT KNOWS ABOUT IT AND AGREES TO IT. THE FAMILY SHOULD ALSO BE AWARE.



REMEMBER: A DNACPR FORM SHOULD NOT BE PUT INTO THE HOME OF A PATIENT WHO HAS MENTAL CAPACITY UNLESS THE PATIENT KNOWS ABOUT IT AND AGREES TO IT. THE FAMILY SHOULD ALSO BE AWARE.

Appendix E

Decision Making Framework

Is cardiac or respiratory arrest a clear possibility for the patient?

NO → It is not necessary to discuss CPR with the patient unless they express a wish to discuss it.

YES ↓

Is there a realistic chance that CPR could be successful?

NO → If a DNACPR decision is made on clear clinical grounds that CPR would not be successful should be a presumption in favour of informing the patient of the decision and explaining the reason for it. Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation.

YES ↓

Does the patient lack capacity AND have an advanced decision specifically refusing CPR OR have an appointed attorney, deputy or guardian?

YES → Where the patient lacks capacity and has a welfare attorney or court appointed attorney deputy or guardian, this representative should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussion about the patients care.

If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

If a patient has made an advanced decision refusing CPR, and the criteria for applicability and validity are met, this must be respected.

If an attorney, deputy or guardian had been appointed they should be consulted.

NO ↓

Does the patient lack capacity?

YES → Discussion with those close to the patient must be used to guide a decision in the patient's best interests.

NO ↓

Is the patient willing to discuss his/her wishes regarding CPR?

NO → 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.

YES ↓

The patient must be involved in deciding whether or not CPR will be attempted in the event of cardiorespiratory arrest.

- If cardiorespiratory arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting CPR.
- Anticipatory decisions about CPR are important part of high quality health care for people at risk of death or cardiorespiratory arrest.
- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.
- Decisions about CPR require sensitive and effective communication with patients and those close to patients.
- Decisions about CPR must be documented fully and carefully.
- Decisions should be reviewed with appropriate frequency and when circumstances change.
- Advice should be sought if there is uncertainty

Adapted from Guidance from the British Medical Association, the Resuscitation Council (UK) and The Royal College of Nursing (Previously known as the "Joint Statement") Decisions relating to cardiopulmonary resuscitation 3rd Edition, October 2014

Appendix F

MENTAL CAPACITY ACT 2005 GUIDANCE

Mental Capacity Act (MCA) 2005 (Amended 2007)
The MCA came into operation in 2007. It serves 2 functions:

1. To provide a statutory framework which empowers and protects people who may lack capacity to make certain decisions for themselves
2. To provide a framework for people who wish to plan ahead for a time when they may lack capacity

Clinicians are expected to be familiar with and adhere to the MCA's principles, understand how it works in practice and apply this where applicable when making DNACPR decisions. Staff working with people lacking capacity should be familiar with the MCA's Code of Practice and follow its guidance.

Principles
The MCA is underpinned by five key principles set out in Section 1:

1. Every Adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. Assumptions should not be made that someone cannot make a decision for themselves just because they have a particular medical condition or disability.
2. People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means that you should make every effort to encourage and support the person to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.
3. People with capacity have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.
4. Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.
5. Anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms. Professionals making decisions on behalf of those who lack capacity on a best interests basis should always try to choose the option that interferes the least with the individual's day-to-day life. However, sometimes a level of restraint may be required in the person's best interests.

Capacity
Capacity is time and decision specific. In accordance with the first principle of the MCA, everyone over the age of 16 is presumed to have capacity unless it is found otherwise. The MCA lays down a framework that must be followed when services are working with people who may, permanently or temporarily, lack the capacity to make all, or some, decisions about their treatment and care for themselves.

Assessing Mental Capacity
The Two-stage Test (the diagnostic test)
Consider the following questions when assessing whether an individual has the capacity to make a decision:

1. Does the person have an impairment of mind or brain, or is there some sort of disturbance affecting the way their mind and brain works, either on a temporary or a permanent basis?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made (see functional test below)

The Four-step functional test (the functional test)
According to the MCA, a person is unable to make their own decision if they cannot do one or more of the following:

i. Understand the information relevant to the decision, including what will happen if they do or do not make the decision;
ii. Retain that information;

iii. Use or weigh that information up in making their decision; and
iv. Communicate their decision by any means, including talking or making sounds, movements (however slight, e.g. squeezing another's hand, blinking can be sufficient), signs (e.g. drawing pictures) or any other means (principle 2 is particularly relevant here)?
v. All details of a person's Mental Capacity Assessment must be documented in the person's notes. This information should be shared with all relevant health and social care staff involved in the person's care (including IMCAs).

Best Interests
Where a person is unable to make a decision for themselves, and all reasonable efforts have been made in an attempt to support them to make their own decision, any decision made on their behalf must be made in accordance with their best interests. The MCA does not fully define 'best interests' but case law has confirmed that best interests looks at both medical and non-medical factors. Every patient, and every case, is different and must be decided on its own facts. Decision makers must look at welfare in the widest sense, taking into account not just medical but social and psychological factors. In order to assist in decision making, the MCA sets out a checklist of factors which must be considered.

Best Interests Checklist
- Is there a relevant substitute decision maker by virtue of a WPA or Court Appointed Deputy?
- Is there a valid and applicable ADRT to refuse treatment?
- Assess whether the person may gain capacity; if so, can the decision wait?
- Involve the person in the decision as much as possible.
- Explore the person's past and present views, culture, religion and attitudes.
- Do not make assumptions based on a person's age, appearance, condition or behaviour.
- If the decision relates to the provision or withdrawal of life-sustaining treatment, the decision must not be motivated by a desire to bring about the person's death.
- Consult interested family and friends.

Decision-maker responsibilities
DNACPR decision-makers must:
- Involve the person.
- Have regard for the past and present wishes and feelings, especially written statements which may be in the form of an advance care plan (ACP).
- Consult with others who are involved in the care of the person e.g. carer, LPA.
- Not make assumptions based solely on the person's age, appearance, condition, disability or behaviour.
- Ensure a valid and applicable ADRT (see below for details) to refuse CPR is respected even if others think that this decision is not in the person's best interests.
- Respect any LPA and/or ADRT including end of life treatment.
- Seek the appointment of an IMCA were the person lacks capacity and there is no one to speak on their behalf other than a paid carer.
- Be kept under review.

Decisions Reserved to the Court of Protection
There are certain serious decisions are reserved to the Court of Protection and cannot be taken without recourse to the Court. This includes cases where there is a dispute about whether a particular treatment will be in a person's best interests. It is essential that decision makers are familiar with sections 6.18 and 8.18 of the Code of Practice.

Advance Decision to Refuse Treatment
A DNACPR is a clinical decision made on best interests relevant to the disease of the person whereas an ADRT is the person's own decision. The MCA creates statutory rules with clear safeguards so people can make an ADRT including end of life treatment if they should lack capacity in the future. Where a patient wishes to make an ADRT to refuse life-sustaining treatment, it must comply with the following legal requirements:

- It must be in writing
- It must be signed by the person (or in their presence if they are unable to do so themselves)

- It must be witnessed
- It must include a statement that it is to apply even if life is at risk

ADRTs which do not relate to refusal of life-sustaining treatment do not have to be in writing, although this is always preferable if possible. The ADRT does however need to be specific and clearly relate to the treatment in question. Where an ADRT is provided verbally, this should be recorded in detail in the patient's records and the accuracy confirmed with the patient.

A valid and applicable ADRT is classed as a contemporaneous decision and must be followed, unless the patient withdraws the decision (a withdrawal does not need to be in writing, even where it relates to an ADRT refusing life-sustaining treatment) or has indicated that they have changed their mind (e.g., by acting inconsistently with its terms).

A DNACPR is not an ADRT; it is a legal document informing healthcare professionals of a medical direction. If the person has a valid and applicable ADRT refusing CPR a copy should be attached to the back of their DNACPR form.

The decision maker should make reasonable efforts to ascertain whether a patient who may be considered for a DNACPR decision has made either an ADRT or an advance decision to refuse end of life treatment.

There is sometimes confusion regarding Advance Care Planning (ACP), advance decisions and DNACPR. Some basic definitions are:

Advance Care Planning	**Advance Decisions to Refuse Treatment**	**DNACPR**
This is a process of discussion between an individual and their care providers irrespective of discipline. The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.	These must relate to a refusal of specific medical treatment and can specify circumstances. It will come into effect when the individual has lost capacity to give or refuse consent to treatment. Careful assessment of the validity and applicability of an advance decision is essential before it is used in clinical practice. Valid advance decisions, which are refusals of treatment, are legally binding.	A DNACPR decision applies to CPR only, other ceilings of treatment need to be discussed. A DNACPR is a method of communicating a medical instruction, a clinical decision made on best interests relevant to the disease of the person.

When do you need an IMCA?
The MCA makes provisions for an Independent Mental Capacity Advocate (IMCA) Service. This provides an independent advocate to support particularly vulnerable people who lack capacity to make important decisions and who have no one to appropriately consult regarding certain decisions, i.e. family or friends.

The MCA places an obligation on Local Authorities and/or NHS bodies to instruct and/or consult an IMCA when making decisions for a person who lacks capacity if:

- The decision is about serious medical treatment provided by the NHS
- It is proposed that the person be moved into long-term care of more than 28 days in hospital or 8 weeks in a care home
- A long-term move (8 weeks or more) is being considered, for example, to a different hospital or care home.

An IMCA will not be the decision maker but the decision maker will have a duty to take into account the information given by the IMCA.

uDNACPR Decisions and Mental Capacity in relation to (NW) Adult uDNACPR Policy

Informing/ involving the person and others in DNACPR Decision. CPR is unlikely to be successful (NW) form Section 1a)
When a DNACPR decision has been made on the basis that CPR is unlikely to be successful, the patient should usually be informed of the decision and why CPR is an inappropriate treatment, unless such a discussion would cause them harm (NB –the fact that the patient may find the conversation distressing is not sufficient to warrant their exclusion from the process). By keeping the patient informed, it allows them to make further decisions for themselves in light of the DNACPR. If the person was not informed of the decision at time of making, due to being too unwell, it is important that they are informed at the earliest appropriate. Any such decisions should be kept under review and involve carers/relatives /LPAs and IMCAs as indicated elsewhere in this policy.

If the person lacks capacity the relevant other/ LPA or IMCA, if appointed, MUST be told of the decision when it is made or prior to discharge.

CPR may be successful but will not be of overall benefit to the individual (form Section 1b)
If the person has mental capacity the burdens and benefits of CPR need to be discussed and a decision reached in partnership. If the person does not have capacity, their relevant others must be consulted to help establish what is in the patient's best interests. If the person has made a LPA, appointing a Welfare Attorney to make the relevant decisions on their behalf, that person will have decision-making responsibility and therefore must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the person if this power is included in the original LPA. You need to check this by reading the LPA. If there is no one appropriate to consult with and the person has been assessed as lacking capacity then a referral should be made for appointment of an IMCA.

The following needs to be recorded;

- State clearly in the notes what was discussed and agreed.
- If the decision was not discussed with the person, state the reason why this was inappropriate.
- State the names and relationships of relevant others with whom this decision has been discussed.
- A detailed description of such discussion should be recorded in the clinical notes.

There is a valid advance decision to refuse CPR in the following (NW form Section 1c)
Where there is an ADRT to refuse CPR, it is important to check its validity and applicability by confirming:

1. Is the ADRT refusing CPR in the current circumstances?
2. Is it in writing, signed by the patient?
3. Has it been witnessed and signed by the witness?
4. Does it contain the statement that it is to apply **'even if life is at risk'**
5. Has the person been consistent with their ADRT (and not indicated that they have changed their mind or withdrawn their decision)?

If the answer to all the above is 'Yes' the ADRT is valid and applicable. If the ADRT contains specific circumstances when CPR would not be appropriate write these on the DNACPR form. If there is a valid and applicable ADRT, a copy on white paper should be kept with the DNACPR form

Remember a person can change this decision at any time

Please Note:
Nothing in this policy overrules the organisation's general MCA training/policy or the MCA itself or the MCA's Code of Practice. It is important that staff are familiar with MCA and the Code of Practice and have attended relevant training.

For further information: ADRT	www.adrtnhs.co.uk www.ncpc.org.uk
Human Rights Act 1998	www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1
MCA	www.legislation.gov.uk/ukpga/2005/9/contents
MCA Code of Practice	www.publicguardian.gov.uk/mca/code-of-practice.htm

Appendix G

Add Own Logo

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

Frequently Asked Questions

The primary goal of healthcare is to benefit patients, by restoring or maintaining their health, and cardio-pulmonary resuscitation (CPR) is a prime example of a potentially life-saving intervention. However, whilst patients who have an acute event, such as a heart attack, may recover with CPR, the chances of survival are much lower for patients who suffer this in the context of the progression of a life limiting illness.

As such, a regional unified **Do Not Attempt Cardiopulmonary Resuscitation** (DNACPR) form, policy and patient information leaflet for use in all care settings has been developed. **The policy carries a clear message that it is related to cardio-pulmonary resuscitation only, for adults aged 18 and over**. This ensures patients known to be approaching the end of life receive appropriate care and treatment, and are not resuscitated inappropriately or against their wishes.

This document is intended to answer some of the frequently asked questions around the implementation of the unified DNACPR policy in the North West region.

Question	Answer
What does a DNACPR decision mean?	If someone's heart or breathing stops as expected due to their medical condition and they have a DNACPR order, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Any DNACPR decision **does not mean "Do Not Treat".** This should not affect other aspects of care and treatment should continue to be given; for example treatment of life threatening anaphylaxis, choking, infection, nutrition or hydration.
If there is a DNACPR form is it ever right to initiate CPR?	There is always a clinical judgment to be made at the time of a cardiopulmonary arrest. Where the arrest is witnessed and it is clearly due to an easily reversible cause it may be appropriate to initiate CPR irrespective of the DNACPR order, e.g. choking. This should, if appropriate, be explained to the patient at the time of making a DNACPR decision.
Are all care providers adopting the new unified policy?	Not all care providers in Cheshire & Merseyside have adopted the unified policy and form and those with a policy currently in place are committed to using the new unified 'Do not attempt Cardio-Pulmonary Resuscitation (uDNACPR) form. The form is transferrable between settings, including during transport.
How do I know that the person who signs the form is authorised to do so?	GPs in Primary Care and senior doctors and Consultants in Acute or Hospice settings can sign the form. Section 7.6 Consultants/ General Practitioners/Doctors making DNACPR

	decisions must: • be competent to make the decision • verify any decision made by a delegated professional at the earliest opportunity • ensure the decision is documented (See 8.6) • involve the individual, following best practice guidelines when making a decision, (See 8.5) and, if appropriate, involve relevant others in the discussion • communicate the decision to other health and social care providers • review the decision if necessary
Have care homes adopted the new policy and form?	Yes each locality has supported the dissemination of information into their care home sector. The care home settings have adopted the form and have/will be receiving support in the form of information and an education package delivered locally.
Do relatives of the patient have to be told about the DNACPR decision?	The regional DNACPR process is based on good communication practice and DNACPR decisions should be discussed with relatives where appropriate provided the patient has given consent.
How long is the form valid for, when should it be reviewed and should it be reviewed?	This decision will be regarded as ongoing unless: • A definite review date is specified • There are improvements in the person's condition • Their expressed wishes change where a 1b & 1c decision is concerned. All DNACPR decisions are subject to ongoing monitoring to ensure they remain appropriate; it is recommended that a review date be considered and entered on the DNACPR form if appropriate. It is important to note that a review date does not equate to an expiry date for ongoing decisions and remains clinically appropriate and valid.
If there is a review date and it has passed are the forms invalid?	It is still valid. See section of policy 2.11 It is important to note that a review date does not equate to an expiry date for ongoing decisions and remains clinically appropriate and valid. All reviews should be documented in the patient's records. Reassessing the decision regularly does not mean burdening the patient and their family with repeated decisions, but it does require staff to be sensitive in picking up any change of views during discussions with the patient or their family.
Can the patient change their minds about a DNACPR decision?	They can revoke an Advance Decision to Refuse Treatment (ADRT) but this does not mean that CPR would necessarily be appropriate for that patient and decisions would be made by the doctor on the basis of the patient's medical condition. DNACPR is a medical decision and a patient cannot demand clinically inappropriate treatment.
Who can make a DNACPR decision?	Each area has their own criteria for who has responsibility for making the DNACPR decision. Most have restricted this to Consultants, senior doctors and GPs.
Is the DNACPR form valid across care boundaries, i.e. hospital to home or	Yes - as long as the senior clinician who takes over clinical responsibility for the patient in the new care setting is informed of, and is happy to take responsibility for the DNACPR decision as

hospital to hospice?	appropriate to their clinical assessment. This responsibility also involves an undertaking to review the decision, if appropriate.
Can the DNACPR form ever be photocopied?	The lilac copy of the form is the only valid copy held by the patient. Any other copies are for audit and medical records. These can be photocopied but must be scored through and "COPY" written across A photocopy cannot be used as a valid form, **only the lilac copy**.
How many copies of the form should there be?	The form is completed in triplicate. The lilac copy is retained by the patient and is the only valid copy; one white copy should be kept for audit and the 2nd white copy should be retained in the patients' notes. NB: the newer version of the form has a lilac band down the right margin of the white audit copy to ensure this is easily identifiable. If the form is printed electronically the valid patient copy should be printed on lilac paper with the 2 copies for audit and case notes printed on white paper.
What if the form is lost?	An entirely new form should be completed by the patients' doctor.
What if a patient with a DNACPR form deteriorates unexpectedly?	Any patient who deteriorates unexpectedly should be assessed and managed appropriately, regardless of whether there is a DNACPR form or not. This may involve calling 999 or putting out an arrest call in hospital to summon rapid medical assistance if that is appropriate. The decision not to attempt the procedure of cardio-pulmonary resuscitation detailed on the form does not preclude other interventions in situations other than a cardiopulmonary arrest but it may prompt different questions to be asked about what is happening to the patient e.g. respiratory arrest
How can you ensure the ambulance service is informed of the right person having a DNACPR form?	It is the responsibility of the person completing the DNACPR form to ensure that the ambulance service is aware of the DNACPR decision by notifying North West Ambulance Service (NWAS) using the web based Electronic Referral & Information Sharing IT System (ERISS) or Electronic Palliative Care Coordination System (EPaCCs), whichever is available and in use. It is the individual's responsibility to know what guidance is in place in your organisation for the information sharing process.
What is ERISS?	ERISS is the North West Ambulance Service's Electronic Referral & Information Sharing IT System that will inform NWAS if a patient at an address has an order in place. It is a web based system and can be registered with and logged into by individuals (much like internet banking). Once a registration is set up an individual can enter patient details to the system, which in turn will flag up on the NWAS system when an ambulance is called to that address. www.eriss.nhs.uk
How will patients be flagged up if they have a current DNACPR order when they come into A&E, for example?	If the patient is taken to A&E via ambulance the paramedics will know, via the Electronic Referral and Information System (ERISS), which will flag up a patient at that address.

	The paramedic should be able to access the form at the address and will inform the staff on arrival at A&E that the patient has a DNACPR in place. It is the responsibility of the patient and/or carers to have the lilac form in an accessible location and this should be discussed with them so they are aware of their responsibility. If the patient presents themselves at A&E it is the patient and/or carers responsibility to take the form with the patient and present to the A&E staff.
Why was the decision made to give the patient the form to take home, would it not be easier to keep it in their notes?	The decision belongs to the patient therefore it needs to be where the patient is. If the form is in the notes it will not be easily accessible to all health care professional looking after that patient at home. The patient will decide where to keep the form at home, whether this is in their care notes in the house, or in a drawer etc. and this will be highlighted on the DNACPR form at the time of completion on a tear off slip that can be kept in an easily accessible place.
If the patient has an old form and a new form is completed, what happens to the old form?	Cross the old form with 2 diagonal lines and write clearly between the lines 'Transferred to new documentation' once the new form is complete.
What happens if the consultant / GP refuses to write these forms even if they agree resuscitation would be futile / inappropriate?	If the patient is asking for this decision and is competent to make the decision their wishes should be respected. If it is refused, they are within their rights to seek a second opinion; the patient can ask for a second opinion to be sought from another consultant / GP.
Whose responsibility is it to inform all other carers / care providers of the DNACPR decision?	It is the responsibility of the person completing the DNACPR form to ensure that other healthcare teams involved in the care of the patient are aware of the DNACPR decision. This may be done electronically, verbally, by discharge letter or by safe fax. It is the patient's responsibility to tell other family members, friends and carers. However, it is good practice to discuss the decision with family members and this should be encouraged. Please ensure that all health and social care staff who have been informed, are aware of their responsibility to document the decision in their own records, as the original stays with the person.
Who is going to pick this up on referral out, especially into community - will GPs do this?	Within the policy it states that: 8.8.4 Current discharge letters must include information regarding this decision. If the DNACPR decision has a review date it is mandatory that the discharging doctor speaks to the GP to inform them of the need for a review. This should be followed up with a discharge letter.
In the future will nurses be trained to write a DNACPR decision?	In some areas some specialist nurses have training in making DNACPR decisions but this does not happen in every area.

If the patient is very deaf it makes a discussion about DNACPR extremely unproductive and certainly not in confidence. Any suggestions?	Take the patient to a private room, ensure their hearing aids are working, someone who signs, if necessary, and their relevant others. The patient information leaflet is an adjunct to the discussions.
If the patient does not speak or read English it can make a discussion about DNACPR extremely unproductive. Any suggestions?	In these circumstances a translator can be used to facilitate discussions with the patient.
If a patient is admitted to an acute Trust and a consultant decides to cancel the DNACPR decision, can they do that?	On discussion with the patient, or their advocate, should there have been changes to the patient's health then the consultant can discuss this with the patient. This may lead to a decision for the form to be cancelled. If the patients clinical situation or own decision has not changed there would be no reason to cancel the DNACPR decision. Having a different doctor in charge of a patients care should not be a reason to cancel.
What about people with mental and learning disabilities? Who completes the form then?	All DNA CPR decisions should be underpinned by the Mental Capacity Act. The form should be completed by the decision maker identified within the policy.
When do I start using the new lilac unified DNACPR form?	The new policy and form will be implemented on the agreed date within each area and you will need to use the form from this date onwards.
What should I do with my supply of old and unused DNACPR forms?	Any old forms were not recognized outside of the patient's current setting and therefore would not have been valid as a unified form. The value of a unified form is that it will be recognized by the paramedics. Any old forms should be shredded or put in confidential waste bins.
I've run out of patient leaflets, do I need them?	Yes. It is important that the patient has information around the DNACPR decision in case they wish to refer to this after the discussion. It is also helpful for them to share with family and friends should they wish. If you run out of hard copies of the leaflet, you can print a copy, although this should rarely occur as there is one patient leaflet per form in the packs supplied or purchased. The leaflet may only need to be printed if you are printing your forms electronically. *Organisations to insert their own process for producing the leaflets in braille, audio, languages*
How do I fill in the form?	A simple presentation has been developed to outline the correct procedure for completing the DNACPR form contained within the education toolkit appendix G.
What if an error is made during completion of the	If it is a small error a single line cross out with signed and dated acknowledgement is sufficient.

form?	If the form needs to be rewritten, cross the form with 2 diagonal lines and write clearly between the lines 'Void due to error,' do not discard as it is important for audit.
Who can I contact if I have a query?	If you have a query regarding the policy or form you can contact your local lead or Resus Officer.
Are there any plans for public awareness campaign?	For Cheshire and Merseyside this was discussed and a decision made by CCGs not to hold a formal media event as in some cases policies were already in place and this was an update to their current policy. Some organisations have decided to make the policy available to the public on individual websites.
Has the video package happened yet re training?	No
Is there another Steering Group meeting planned?	Review planned for April 2015
If we have unused forms should we destroy these or can we use them?	The lilac forms have been updated in September 2014. Continue to use old forms until new forms are available.
Can we still fax forms to NWAS to update them?	NWAS have requested we promote the use of ERISS as the preferred information sharing system.

Appendix H

How to complete the Regional Unified Do not attempt Cardio-Pulmonary Resuscitation (DNACPR) Form

Information for Decision Makers

Acknowledgement: Adapted from Liverpool CCG, with kind permission

When should I use the DNACPR form?

- You should consider using the DNACPR form (as part of Advance Care Planning), if you would not be surprised if the patient were to die in the next year.

Where can I get a copy of the DNACPR form?

- Your organisation has been supplied with a pack of DNACPR forms, along with copies of the patient information leaflet.
- To obtain more contact..... **[to be added once agreed]**

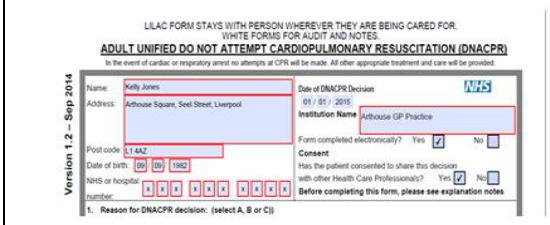
About the form

- The DNACPR form is designed to be transferable between all care settings and to be held by the patient.
- The form carries a clear message that it is related to cardio-pulmonary resuscitation only. This ensures patients known to be approaching the end of life receive appropriate care and treatment, and are not resuscitated inappropriately or against their wishes.
- It also takes into consideration the Mental Capacity Act (2005) and gives a legitimate framework in which to discuss cardio-pulmonary resuscitation at the end of life.

How to complete the DNACPR form

Using a black ball-point pen, clearly complete:

- The persons full name
- Address
- Date of birth
- NHS or hospital number
- Date of writing the decision
- Institution where the form is being completed
- If the patient has consented to share this decision with other Health Care Professionals


LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR.
WHITE FORMS FOR AUDIT AND NOTES.

ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

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

Version 1.2 – Sep 2014

Name: Kelly Jones

Address: Arthouse Square, Seel Street, Liverpool

Post code: L1 4AZ

Date of birth: 09 09 1982

NHS or hospital number: x x x x x x x x x x

Date of DNACPR Decision: 01 / 01 / 2015

Institution Name: Arthouse GP Practice

Form completed electronically? Yes ☑ No ☐

Consent

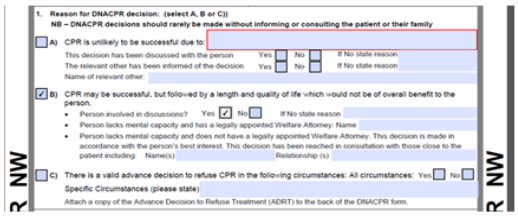
Has the patient consented to share this decision with other Health Care Professionals? Yes ☑ No ☐

Before completing this form, please see explanation notes

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

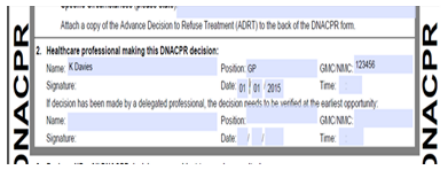
Completing the DNACPR form *(cont). . .*

1. The reason for the DNACPR decision



Completing the DNACPR form *(cont). . .*

- 2. The health care professional making the decision



including signature

Completing the DNACPR form *(cont). .*

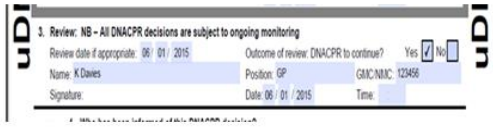
.

This decision will be regarded as ongoing unless:

- A definite review date is specified
- There are improvements in the person's condition
- Their expressed wishes change where a 1b & 1c decision is concerned.

All DNACPR decisions are subject to ongoing monitoring to ensure they remain appropriate; it is recommended that a review date be considered and entered on the DNACPR form if appropriate. It is important to note that a review date does not equate to an expiry date for ongoing decisions and remains clinically appropriate and valid.

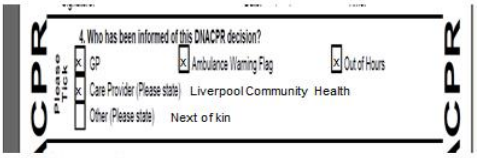
Completing the DNACPR form *(cont…)* Review of the decision



Completing the DNACPR form *(cont). . .*

- It is the responsibility of the person completing the DNACPR form to ensure that other healthcare teams involved in the care of the patient are aware of the DNACPR decision. These may include out of hours GP and nursing teams, the ambulance service, the hospital emergency department, community nurses, palliative care services and other specialist teams involved in caring for the patient. This can be done electronically or by safe fax.
- Please ensure that all health and social care staff who have been informed, are aware of their responsibility to document the decision in their own records, as the original stays with the person.

Communicating the DNACPR decision



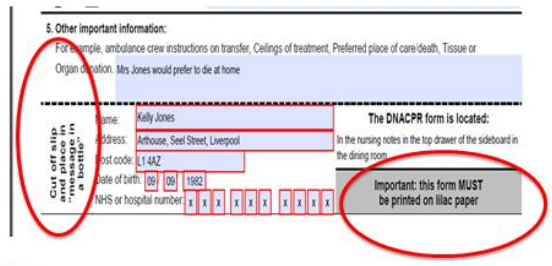
Completing the DNACPR form *(cont)...*

Other important information:

- This needs to be very clear and precise, for example if the patient is transferring care setting, include name, address and telephone number of the destination and next of kin.

Tear off slip:

- Once the form is complete, the tear off slip should be placed in a clearly identified location and the location stated on the form. If the message in a bottle system is available this can be used.



Cancelling a DNACPR form

- If the decision is cancelled, the DNACPR form should be crossed through with two diagonal lines, in black ball-point ink and "CANCELLED" clearly written between the lines.
- The form should be signed and dated by the clinician cancelling the form.

Cancelling a DNACPR form

- It is the responsibility of the person cancelling the DNACPR decision to communicate this to all parties informed of the original decision.

What happens when the form is completed?

- Electronic forms must be printed off on lilac paper, signed and the lilac copy given to the patient. Copies should also be kept for audit purposes and notes.
- If you are using triplicate paper forms – the lilac copy should be kept with the patient, the 1st white copy kept for audit and the 2nd white copy retained in the patients notes.

Appendix I

E-learning for End of Life Care (ELCA)
Curriculum workbook (e-LfH system)

This curriculum workbook supports learners using the learning management system via the e-Learning for Healthcare or e-ELCA website. There are 8 courses. Within each course, there are varying numbers of e-learning sessions, listed in the tables. You do not have to complete all sessions at the same sitting. The display IDs for some of the sessions are not yet visible, so in the meantime, you should locate the session using the course name and session title.

COURSE NAME: INTRODUCTION

Display ID	Session titles	Date completed	Notes/comment
00_01	Introduction to e-learning for End of Life Care		
00_02	Relationship between palliative care and end of life care		

COURSE NAME: ADVANCE CARE PLANNING

Display ID	Session titles	Date completed	Notes/comment
	Advance care planning: principles		
01_01	Introduction to principles of ACP		
01_02	Cultural and spiritual considerations in ACP		
01_03	Benefits and risks of ACP to patients, families and staff		
01_04	ACP in practice: using end of life care tools		
	Advance care planning: context		
01_05	Advance Decision to Refuse Treatment: principles		

01_06	Advance Decision to Refuse Treatment: in practice		
01_07	Mental Capacity Act: aims and principles		
01_08	Mental Capacity Act: in practice		
01_09	Approaching ACP when capacity is uncertain, fluctuating or likely to deteriorate		
01_10	ACP and different trajectories		
	Advance care planning: process		
01_11	Introduction to conducting conversations about advance care planning		
01_12	How to get started and get the timing right		
01_13	How to handle patients' questions and concerns		
01_14	How to document conversations about advance care planning		
01_15	How to negotiate decisions which may be difficult to implement		
01_16	How to review previous ACP decisions		
	Advance care planning: developing practice		
01_17	Developing ACP in your organisation		
01_18	Developing your practice, clinical supervision, further reading		

COURSE NAME: ASSESSMENT

Display ID	Session titles	Date completed	Notes/comments
	Assessment: principles		
02_01	Introduction to principles of assessment in end of life care: part 1		
02_02	Introduction to principles of assessment in end of life care: part 2		
	Assessment: domains		
02_03	Assessment of physical symptoms		

02_04	Assessment of physical function		
02_05	Assessment of psychological well-being		
02_06	Assessment of social and occupational well-being		
02_07	Assessment of spiritual well-being		
02_08	Context of assessment: cultural and language issues		
	Assessment: context		
02_09	Bereavement assessment and support		
02_10	Carer assessment and support		
02_11	Assessing through proxies		
02_12	Assessing those with fluctuating mental capacity		
02_13	Assessing urgent situations with limited information		
02_14	Assessment of dying phase and after-death care		
	Assessment: process		
02_15	First assessment: meeting the patient		
02_16	Identifying the patient's goals and priorities		
02_17	Documentation, communication and coordination		
02_18	Following up assessments and evaluating outcomes		
02_19	Uses and limitations of assessment tools		

COURSE NAME: COMMUNICATION SKILLS

Display ID	Session titles	Date completed	Notes/comments
	Communication skills: principles		
03_01	The importance of good communication		
03_02	Principles of communication		

03_03	Communicating with ill people		
03_04	Talking with ill people: considering the surrounding environment		
03_05	Culture and language in communication		
03_06	Communication skills for admin staff, volunteers and other non-clinical workers		
03_07	Self awareness in communication		
	Communication: basic skills		
03_08	Understanding and using empathy		
03_09	Skills which facilitate good communication		
03_10	Things which block good communication		
	Communication: modes of communication		
03_11	Face to face communication		
03_12	Telephone communication		
03_13	Written communication		
	Communicating: specific contexts		
03_14	Information giving		
03_15	Breaking bad news		
03_16	Communicating with non-English speaking patients		
03_17	Communicating with people with speech and hearing difficulties		
03_18	Communication with children and young people		
03_19	Request for organ and tissue donation		
03_20	Request for euthanasia		
03_21	Legal and ethical issues embedded in communication		
	Communication: challenging scenarios		
03_22	"Am I dying?" "How long have I got?" – handling challenging questions		
03_23	"Please don't tell my husband…." – managing collusion		

03_24	"How dare you do this to me!" – managing anger		
03_25	"I don't believe you, I'm not ready to die!" – managing denial		
03_26	"What will it be like?" – talking about the dying process		
03_27	"Why can't I stay here" "I don't want to stay here" – when preferred place of care cannot be met		
03_28	"I'm not loveable anymore…" – discussing intimacy in end of life care		
03_29	"Why me?" – discussing spiritual distress		
03_30	Discussing 'do not attempt CPR' decisions		
03_31	Discussing food and fluids		
03_32	Silence: the withdrawn patient		
03_33	Distress: the crying patient		
03_34	Dealing with challenging relatives		
03_35	Challenging communication with colleagues		

COURSE NAME: SYMPTOM MANAGEMENT

Display ID	Session titles	Date completed	Notes/comments
	Symptom management: principles		
04_01	General approach to assessment of symptoms		
04_02	Agreeing a plan of management and care		
04_03	Communicating the plan of management and care		
04_04	Individual preferences and cultural influences on symptom management		
04_05	Influence of transition points and crises on decision-making in symptom mx		
04_06	Recognising your own limitations in symptom management		
	Symptom management: pain		

04_07	Assessment of pain		
04_08	Principles of pain management		
04_09	Drug management of pain – core knowledge		
04_10	Opioids in pain management – advanced knowledge		
04_11	Managing different types of pain		
	Symptom management: breathlessness		
04_12	Assessment of breathlessness		
04_13	Drug management of breathlessness		
04_14	Non-drug management of breathlessness		
	Symptom management: nausea, vomiting and constipation		
04_15	Causes of nausea and vomiting		
04_16	Assessment of nausea and vomiting		
04_17	Management of nausea and vomiting		
04_18	Assessment of constipation		
04_19	Management of constipation		
	Symptom management: emergencies		
04_20	Management of bleeding		
04_21	Management of seizures		
04_22	Recognising and managing malignant spinal cord compression		
	Symptom management: last days of life		
04_23	Recognising the dying phase, last days of life and verifying death		
04_24	Managing death rattle		
04_25	Managing agitation and restlessness in the dying phase		
04_26	Managing distress during the dying phase		

	Symptom management: general issues		
04_27	Use of syringe drivers		
04_28	Non-drug interventions in symptom management		
04_29	Symptom management in people with learning difficulties or mental health problems		
04_30	Symptom management complicated by coexisting conditions		
04_31	Management of symptoms associated with wounds		
	Symptom management: mood		
04_32	Assessment of mood		
04_33	Assessment and management of anxiety		
04_34	Management of depression		
04_35	Assessment and management of agitation		
	Symptom management: advanced illness		
04_36	Recognising and managing fatigue		
04_37	Assessment and management of weight loss and loss of appetite		
04_38	Management of sore mouth and other oral problems		
04_39	Assessment of physical and cognitive deterioration in function		
04_40	Management of physical deterioration		
04_41	Management of cognitive deterioration		

COURSE NAME: INTEGRATING LEARNING

Display ID	Session titles	Date completed	Notes/comments
	Initiating conversations about end of life care		

05_01	initiating conversations about EoLC: COPD		
05_02	Initiating conversations about EoLC: cancer		
05_03	Initiating conversations about EoLC: dementia		
05_04	Initiating conversations about EoLC: long term neurological conditions		
	Condition-specific case studies		
05_05	Case study: End-stage cardiac disease		
05_06	Case study: Motor neurone disease		
05_07	Case study: COPD		
05_08	Case study: End-stage renal disease		
05_09	Case study: Dementia		
	Critical situations		
05_10	Scenario: ambulance called to home		
05_11	Scenario: terminal agitation – patient in a care home		
05_12	Scenario: patient dying in acute hospital: optimising situation		
	Scenarios around dying		
05_13	When the dying process is protracted or unexpectedly fast		
05_14	Sudden unexpected death		
05_15	Dying as a prisoner		
05_16	Dying as a homeless person		
05_17	Dying in intensive care unit		
05_18	Treatment and care towards the end of life: good practice decision-making		
	Care after death		
05_19	Care after death I - Introduction to care after death		
05_20	Care after death II – Providing personal care after death		

	Frameworks and tools		
05_21	A unified DNACPR Policy		
05_22	Using the NHS Continuing Healthcare Fast Track Pathway Tool		
05_23	Framework for End of Life Care in Advanced Kidney Disease		

COURSE NAME: SOCIAL CARE

Display ID	Session titles	Date completed	Notes/comments
06_01	Supporting people to live and die well		
06_02	Palliative care social work		
06_03	Assessment in end of life care		
06_04	Support and care planning at end of life		
06_05	Hospital social work		
06_06	End of life care in care homes and domiciliary care settings		

COURSE NAME: BEREAVEMENT

Display ID	Session titles	Date completed	Notes/comments
07_01	Talking about death and dying		
07_02	Assessment of carers' needs		
07_03	Practical support after a bereavement		
07_04	Sudden death and bereavement		

07_05	Emotional support and signposting		
07_06	Children and bereavement		

COURSE NAME: SPIRITUALITY

Display ID	Session titles	Date completed	Notes/comments
08_01	Spirituality and the philosophy of end of life care		
08_02	Understanding and assessing spiritual need and spiritual distress		
08_03	Spiritual care and models of spiritual intervention		
08_04	Spiritual resources and quality of life		
08_05	Spirituality and the multidisciplinary team		
08_06	Spirituality in the community		

Appendix J

ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Consider using this form (as part of Advance Care Planning (ACP)),
if you would not be surprised if the patient were to die in the next year.

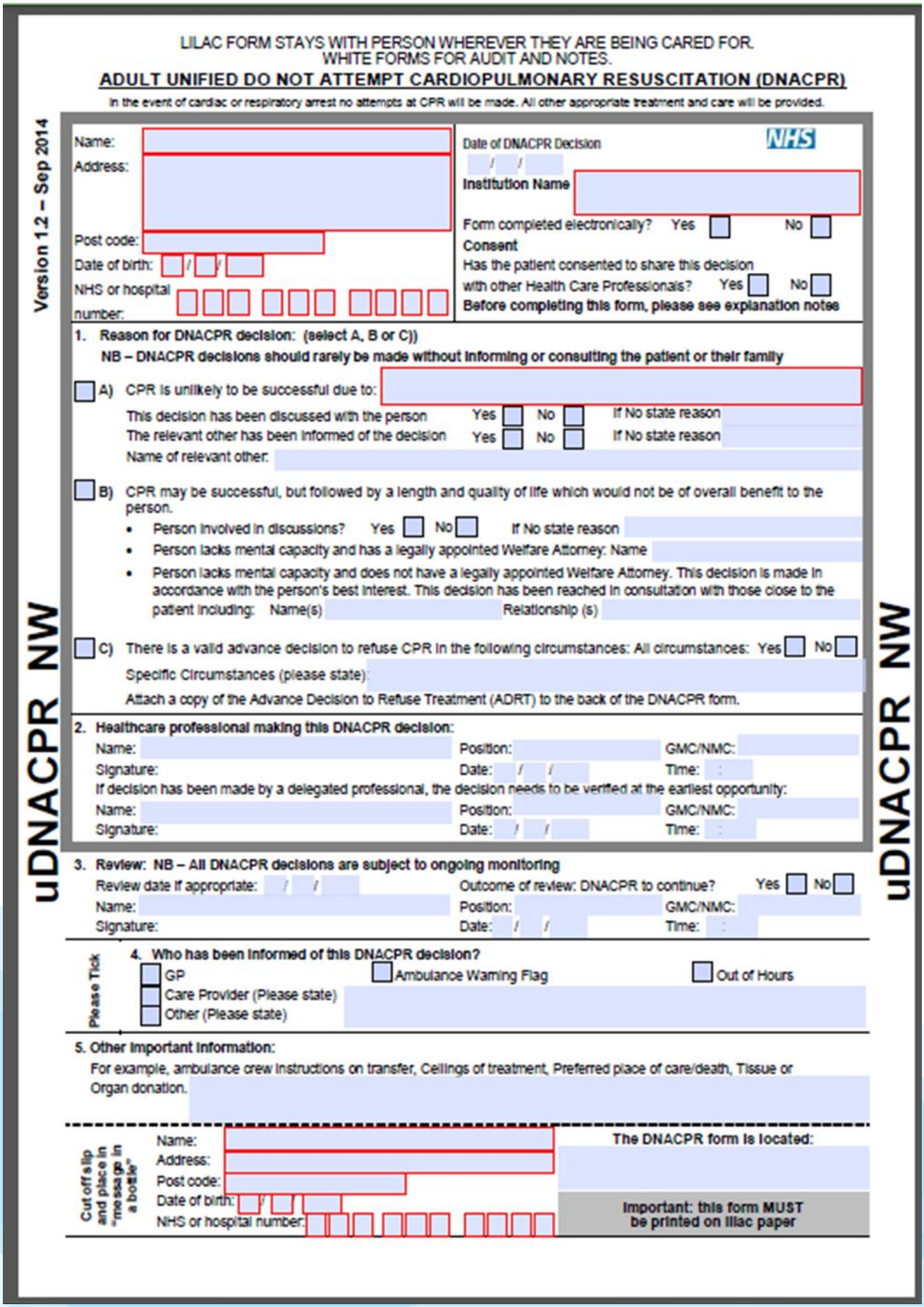
This is **NOT** an Advance Decision to Refuse Treatment (ADRT). www.adrt.nhs.uk

Explanation Notes This form should be completed legibly in black ball point ink

- The person's full name, NHS or Hospital number, date of birth, date of writing the decision and institution name should be completed and written clearly. Address may change due to person's deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address.
- 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 staff. It is the responsibility of the healthcare staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4. on form).
- Electronic form must be printed and signed on lilac paper and copies kept for audit purposes and notes.
- Triplicate forms, keep together until person is discharged/dies or decision is cancelled. Lilac with the person, 1st white copy for audit and 2nd white copy retain in the notes.

Compulsory sections of the form: Top section, Section 1 and Section 2

1.	**Reason for DNACPR decision**	
1.A	**CPR is unlikely to be successful**	**Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person's best interest's.** Be as specific as possible. Patients have a right, under Article 8 of the European Convention on Human Rights, to be consulted / informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. Record the details of discussion or the reason for not discussing in the person's notes.
1.B	**CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the person**	**Summary of communication with person…** State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate. Patients have a right, under Article 8 of the European Convention on Human Rights, to be consulted / informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. If the person does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the person would decide if able to do so. If there is no one appropriate to consult and the person has been assessed as lacking capacity then an instruction to an Independent Mental Capacity Advocate (IMCA) should be considered. If the person has made a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the person if this power is included in the original Lasting Power of Attorney. You need to check this by reading the LPA. If the person has capacity ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives / relevant others with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
1.C	**DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.**	Check for the validity and applicability of the Advance Decision to Refuse Treatment (ADRT). Is the ADRT – 1. Specific to CPR? 2. In writing, signed and witnessed? 3. Contains the statement **'even if life is at risk'** 4. Has the person been consistent with their ADRT? If the answer to all the above is 'Yes' the ADRT is valid and applicable. If the ADRT contains specific circumstances when CPR would not be appropriate write these on the form. Attach a copy of the ADRT to the person's DNACPR form.
2.	**Person making this DNACPR decision/ Verification**	State names and positions. In general this should be the most senior healthcare professional immediately available. If the decision is made by a delegated professional it must be verified by the most senior healthcare professional responsible for the person's care at the earliest opportunity. If the person making the decision is the most senior person, verification is not required.
3.	**Review**	All decisions should be regularly re-assessed at appropriate intervals; such as (if patients condition changes) regardless of whether a review date has been specified. This decision will be regarded as "ONGOING" unless: I) a definite review date is specified II) there are changes in the person's condition III) their expressed wishes change Reviewer needs to complete all details on the form and document the outcome in the notes.
4.	**Who has been informed of this DNACPR decision?**	Please ensure that all health and social care staff who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the person. It is the responsibility of health and social care staff to ensure those who have been informed of the decision are informed if the patient dies, or the form is cancelled.
5.	**Other important information**	This information needs to be very clear and precise. For example, if transferring include name, address and telephone number of destination and next of kin. Ceilings of treatment include where ACP is kept. Preferred place of care should be noted.
	Tear off slip	Complete details and place in "message in a bottle" if available with location clearly stated. For example, "in the nursing notes in the top drawer of the sideboard in the dining room."



LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR.
WHITE FORMS FOR AUDIT AND NOTES.

ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

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

Version 1.2 – Sep 2014

uDNACPR NW

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

Date of DNACPR Decision / /
NHS
Institution Name
Form completed electronically? Yes ☐ No ☐
Consent
Has the patient consented to share this decision with other Health Care Professionals? Yes ☐ No ☐
Before completing this form, please see explanation notes

1. **Reason for DNACPR decision: (select A, B or C))**
NB – DNACPR decisions should rarely be made without informing or consulting the patient or their family

☐ A) CPR is unlikely to be successful due to:
This decision has been discussed with the person Yes ☐ No ☐ If No state reason
The relevant other has been informed of the decision Yes ☐ No ☐ If No state reason
Name of relevant other:

☐ B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person.
- Person involved in discussions? Yes ☐ No ☐ If No state reason
- Person lacks mental capacity and has a legally appointed Welfare Attorney: Name
- Person lacks mental capacity and does not have a legally appointed Welfare Attorney. This decision is made in accordance with the person's best interest. This decision has been reached in consultation with those close to the patient including: Name(s) Relationship (s)

☐ C) There is a valid advance decision to refuse CPR in the following circumstances: All circumstances: Yes ☐ No ☐
Specific Circumstances (please state):
Attach a copy of the Advance Decision to Refuse Treatment (ADRT) to the back of the DNACPR form.

2. **Healthcare professional making this DNACPR decision:**
Name: Position: GMC/NMC:
Signature: Date: / / Time: :
If decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:
Name: Position: GMC/NMC:
Signature: Date: / / Time: :

3. **Review: NB – All DNACPR decisions are subject to ongoing monitoring**
Review date if appropriate: / / Outcome of review: DNACPR to continue? Yes ☐ No ☐
Name: Position: GMC/NMC:
Signature: Date: / / Time: :

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

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

Cut off slip and place in "message in a bottle"
Name:
Address:
Post code:
Date of birth: / /
NHS or hospital number:

The DNACPR form is located:

Important: this form MUST be printed on lilac paper

uDNACPR NW

Appendix K

NHS

Information for you,
your relatives and carers about
Do Not Attempt Cardiopulmonary
Resuscitation (DNACPR) decisions

NHS

September 2014 Version 1.1

12 1

What if I change my mind?

You can change your mind at any time, and talk to any of the healthcare team caring for you.

If you feel you have not had the chance to have a proper discussion with your care team, or you are not happy with the discussions you have had you can follow the formal complaints procedure. Please do not hesitate to keep asking questions until you understand all you wish to know.

Who else can I talk to about this?

If you need to talk about this with someone outside of your family, friends or carers, to help you decide what you want, you may find it helpful to contact any of the following:

- **Counsellors**
- **Independent Advocacy Services**
- **Patient Advice and Liaison Service (PALS)**
- **Patient Support services**
- **Spiritual carers, such as a chaplain.**

Please insert local contact details in box

10

This leaflet explains:

What cardiopulmonary resuscitation (CPR) is

How you will know whether it is relevant to you

How decisions about it are made

This is a general information leaflet for everyone over 18 (if you are under 18 there is a separate leaflet) but it may also be useful to your relatives, friends, carers and others who are important to you. This leaflet may not answer all your questions about CPR, but it should help you to think about the issue and the choices available. If you have any other questions, please talk to one of the healthcare professionals (doctors, nurses and others) caring for you.

A DNACPR decision is about cardiopulmonary resuscitation only and does not affect other treatment.

3

What is CPR?

Cardiopulmonary arrest means that a person's heart and breathing stop. When this happens it is sometimes possible to restart their heart and breathing with an emergency treatment called CPR.

CPR might include:

- **repeatedly pushing down very firmly on the chest using electric shocks to try to restart the heart**
- **'mouth-to-mouth' breathing; and**
- **inflating the lungs through a mask over the nose and mouth or tube inserted into the windpipe.**

Is CPR tried on everybody whose heart and breathing stop?

In an emergency, yes, if it is felt there is a chance it will work. For example, if a person has a serious injury or suffers a heart attack and the heart and breathing stop suddenly. The priority is to try to save the person's life.

However, if people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them. This is particularly true when people have other things wrong with them.

Where a person has expressed his / her wishes not to have CPR this must be in writing in order to be legally binding. The information in this leaflet has been written to help you to decide whether or not you want to make this decision. It is important to remember that your relatives, friends or carers cannot make the decision for you.

An ADRT can be either a written document or a verbal statement. However, if you wish the ADRT to refer to life-sustaining treatment then this must be in writing. You may revoke the decision at any time, either in writing or orally. However it is important that you let the healthcare team and people close to you know of any revocation.

If the ADRT refuses life-sustaining treatment, such as CPR it must:

- Be in writing (it can be written by someone else on your behalf and recorded in your healthcare notes)
- Be signed by you and witnessed (the witness must also sign the document to prove this); and
- State clearly that the decision applies "even if life is at risk".

If you have an ADRT, you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked.

What if I want CPR to be attempted, but my doctor says it won't work?

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there was any real possibility of it being successful. If there is doubt whether CPR might work for you, the healthcare team will arrange a second medical opinion if you would like one. If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion where appropriate about whether these chances are worth taking is very important.

What if I don't want to discuss CPR?

You don't have to talk about CPR if you don't want to, or you can put discussion off if you feel you are being asked to decide too much too quickly. Your family, close friends, carers or those who you feel know you best might be able to help you make a decision you are comfortable with. Otherwise, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you have said.

What if a decision hasn't been made and I have a cardiopulmonary arrest?

The doctor in charge of your care will make a decision about what is right for you. Your family and friends are not allowed to decide for you, unless you have appointed them as a personal welfare attorney and provided them with appropriate authority. Nevertheless, it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be consulted you should let you care team know.

I know that I don't want anyone to try to resuscitate me. How can I make sure they don't?

If you don't want CPR, you can refuse it and the healthcare team must follow your wishes. To ensure your wishes are legally binding, you can make an Advanced Decision to Refuse Treatment (ADRT) (also known as a living will) . An ADRT is a statement made by a mentally competent person aged over 18 years which defines in advance their refusal of specific medical treatment should he/she become mentally or physically incapable of making his/her wishes known.

Do people get back to normal after CPR?

Each person is different. A few people will make a full recovery; some recover but have health problems. Unfortunately, most attempts at CPR do not restart the heart and breathing despite the best efforts of all concerned. It depends on why their heart and breathing stopped and the person's general health. It also depends on how quickly their heart and breathing can be restarted. People who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some people never get back to the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some have brain damage or go into a coma. People with many medical problems are less likely to make a full recovery. The techniques used to start the heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs.

Am I likely to have a cardiopulmonary arrest?

This depends on your medical condition. The health professionals caring for you are the best people to discuss the likelihood of you having a cardiopulmonary arrest. People with the same symptoms do not necessarily have the same disease and people respond to illnesses differently. It is normal for health professionals and patients to plan what will happen in case of a cardiopulmonary arrest.

Somebody from the health care team caring for you, will talk to you about:

- your illness;
- what you can expect to happen; and
- what can be done to help you.

What is the chance of CPR reviving me if I have a cardiopulmonary arrest?

The chance of CPR reviving you will depend on:

- why your heart and breathing have stopped
- any illnesses or medical problems you have (or have had in the past)
- the overall condition of your health.

When CPR is attempted in hospital it is successful in restarting the heart and breathing in about 4 out of 10 patients. On average, 2 out of 10 patients survive long enough to leave hospital. The figures are much lower for people with serious underlying conditions or for those not in hospitals. Everybody is different and the healthcare team will explain what CPR may do for you.

Does it matter how old I am or that I have a disability?

No. What is important is, your current state of health; your current wishes; and the likelihood of the healthcare team being able to achieve what you want. Your age alone does not affect the decision, nor does the fact that you have a disability.

Will I be asked whether I want to discuss CPR?

YES, the healthcare professional in charge of your care will discuss with you whether CPR should be attempted if your heart and breathing stop. The healthcare team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy.

Sometimes, however, restarting a person's heart and breathing leaves them with a severe disability or prolongs suffering. Prolonging life in these circumstances is not always beneficial. Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in these discussions.

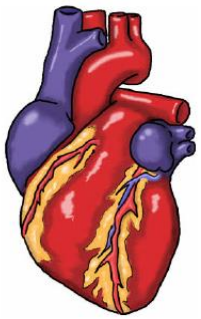
Legally, your family and friends are not allowed to decide or consent on your behalf, so you should inform your family and friends of your wishes. For more information on The Mental Capacity Act please refer to: www.dca.gov.uk/legal-policy/mental-capacity/publications.htm If you have appointed a person with Personal Welfare Attorney (PWA) then they may be able to consent on your behalf in certain situations if you lack capacity.

If it is decided that CPR won't be attempted, what then?

The healthcare team will continue to give you the best possible care. The healthcare professional in charge of your care will make sure that you, the healthcare team, and the friends and family that you want involved in the decision know and understand the decision. There will be a note in your health records that you are 'not for cardiopulmonary resuscitation'. This is called a 'do not attempt cardiopulmonary resuscitation' decision or DNACPR decision.

Appendix L

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust



What happens when your heart and breathing stops

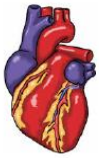
This is an EasyRead version of:
Decisions about cardiopulmonary resuscitation (CPR) September 2011

About this leaflet

This leaflet tells you about what happens if your heart stops and how it might be started again. This is called CPR for short.

Your family, friends and support workers might want to read this leaflet as well.

If you have any more questions after you have read this leaflet, you can ask the people who support you to talk to your health care team.



What is CPR?

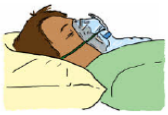
If your heart stops working and you stop breathing, CPR may help start your heart again.

1

When someone does CPR, they may:

- push down on your chest very firmly and lots of times

- use electric shocks on your chest



- put a mask over your nose and mouth to help you to breathe

- put a tube into your mouth to help you to breathe.

2

Does everyone get better after CPR?

Everyone is different. Some people get better and some people will still be ill.

Sometimes people are not able to get your heart and breathing to start again.

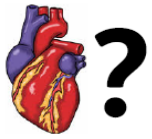
Will my illness mean my heart and breathing stop working?

Everyone is different. Your health team will talk to you about your illness and whether your heart and breathing might stop working one day.

They can tell you what might happen.

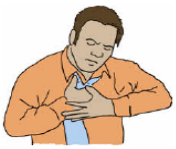
3

If I need CPR, will I get better?



Lots of things make a difference to whether you get better or not:

- why your heart and breathing have stopped working



- if you are ill or have been ill before

- how good your health is.

4

It is not important how old you are or if you have a disability.

These things are important:

- how good your health is

- what you want to happen

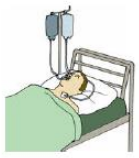
- whether the right people are able to make what you want happen.

5

Who will decide if I have CPR?

You and your doctor will decide if you should have CPR if your heart and breathing stop working.

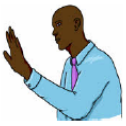
Your health care team (HCT) will look at whether CPR is right for you or not.



Sometimes, people who have had their heart and breathing started again may not fully recover or may not get better.

It is important your health care team know what you think about having CPR.

6



What if I do not want to decide?

You do not have to talk about this if you do not want to.

If you feel someone is making you decide too quickly, you do not have to decide straight away.

If you find it difficult to decide, you can speak to your family and friends.

If you cannot decide, your doctor can speak to you and then decide for you thinking about what you have said.

7

What if I cannot decide and my heart and breathing stop working?

Your doctor will decide what to do.

The health care team may speak to your family and friends to find out what you want to happen. Your family and friends cannot decide for you.

If there are people you do or do not want us to speak to, you should tell the health care team.

What if I do not want CPR?

If you have already decided you do not want CPR and your heart and breathing stop working, the health care team will still make sure you have the right care but they will not do CPR.

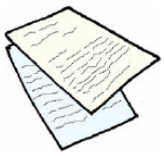
You need to write down that you do not want CPR and sign it. Someone who has seen you sign the paper must also sign to say this. This is called an advanced statement.

You will not get CPR until you say you want it again.

You need to tell the health care team and they will take a copy. They will make sure your doctor's notes say that you do not want CPR.

If it has been decided I will not have CPR, what happens?

The health care team will carry on giving you the best care and treatment.



The decision will be written in your notes.

What if I want CPR to be tried, but my doctor says it will not work?

You cannot make doctors do something that will not work. But they will try CPR if there is even a chance it will work.

If they think that CPR will not work, the health care team will ask someone else to come and see if they agree or not.

They will listen to what you and your friends and family have to say.

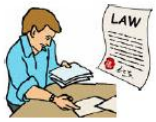
What if things change or I change my mind?

Every time you are checked in hospital, the decisions about your health and what you want to do are checked.

You can change your mind at any time. You can speak to any of the health care team looking after you.

Can I see what's written about me?

You can see any information that is written down about you. You can ask the health care team to show you. They can explain anything you do not understand.



The law says you can look at this information and you can have a copy of it. Sometimes, you might need to pay for this.

Who else can I talk to?

You can telephone The Spiritual Care team at any time day or night:

0151 426 1600

PALS
Patient Advice & Liaison Service
We're here to help

Patient advice and liaison service (PALS):

0151 430 1144

or:

017444 646465

If you feel you have not been able to speak to the health care team in the way you would like to, or you are unhappy about anything, you can contact:

They can help you or your family or friends with anything you want to say or ask or if you want to make a complaint.

Where can I get more information?

Resuscitation Council (UK)

Telephone:

020 7388 4678

Website:

www.resus.org.uk

Age UK

Telephone

0800 169 6565

Website:

www.ageuk.org.uk

To contact us:

Resuscitation services

Telephone:

0151 430 1888

Or:

0151 430 1724

Whiston Hospital
Warrington Road
Prescot
L35 5DR

Credits

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To contact Inspired Services:

www.inspiredservices.org.uk

Appendix M

25 NOVEMBER 2014 CI345

FOR ACTION

DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR} & NORTH WEST REGIONAL DNACPR POLICY UPDATE

The regional DNACPR policy is designed to ensure that a common decision making process is used by all healthcare professionals, where the decision and completed form 'follows the patient' across different care organisations. This reduces the risk of inappropriate resuscitation decisions; improves communication between organisations and supports safer clinical decision making. A distinctive lilac coloured DNACPR form is used as part of the regional DNACPR Policy to record the decisions.

While the regional DNACPR Policy and form is in use across a large proportion of the North West, it does not mean that other forms or methods or recording resuscitations are invalid.

Cumbria and North Lancashire CCGs have adopted an alternative policy called Deciding Right. The form used with this policy is white with red borders. The Wirral and Fylde and Wyre CCGs have also adopted local policies with different forms.

Validation of all DNACPRS

DNACPR decisions are often recorded on a form approved by the organisation providing the care for the patient. The design and content of these forms can vary significantly. Care planning documents (particularly for children) can often contain DNACPR sections and formal letters can also be used to communicate resuscitation instructions to other professionals.

It is important to note that all of the above methods are acceptable methods for recording and communicating resuscitation decisions providing the following criteria are met:

1. The DNACPR must be specific to the patient and their clinical circumstances
2. It must be signed and dated by a senior clinician (normally GP or consultant)
3. If a review date is specified, then it must be within the review period (DNACPRs are often not for review and may state 'indefinite')
4. Letters must be on formal headed paper and typed.
5. There must be a clear instruction of what care is not to be provided.

Every effort must be made to ensure the patient's identity is confirmed and matches the details on the DNACPR.

A DNACPR tick box on a care planning document (in the absence of any other DNACPR documents) is not sufficient for making resuscitation decisions.

Valid DNACPRs are applicable to patients who are in the dying phase (hours to live), peri-arrest or who have just died.

However, there may be occasions where the DNACPR is not applicable to the patient's clinical circumstances. On these occasions, the DNACPR may need to be temporarily suspended:

- Uncommonly, some patients (for whom a DNACPR decision has been established) may develop cardiac arrest from a readily reversible cause. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.

- Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation, such as anaphylaxis, choking or trauma. CPR would be appropriate while the reversible cause is treated.

- Pre-planned: Some procedures could precipitate a Cardiac Arrest, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended.

In such cases, ambulance clinicians should seek clinical advice from an Advanced Paramedic or senior clinician responsible for the patient (normally the GP) without delay.

In cases where the DNACPR decision cannot be validated, is unclear or there are indications that the patient is end of life (death was expected to occur), then staff must continue to provide care and treatment (including Basic Life Support for cardiac arrests) and seek further advice from an Advanced Paramedic.

A copy of the new NW DNACPR policy and documentation can be found:

https://intranet.nwas.nhs.uk/directorates/medical-directorate/udnacpr/

Information on the Deciding Right Policy and Form (for Cumbria and North Lancashire) can be found at:

http://www.cnne.org.uk/end-of-life-care---the-clinical-network/decidingright

Please contact your local Senior or Advanced Paramedic for further advice. For further information on the NW DNACPR Project, please contact eolc@nwas.nhs.uk .

STEVE BARNARD
Head of Clinical Governance

Appendix N

North West Ambulance Service NHS
NHS Trust

Delivering the right care, at the right time, in the right place

Introducing ERISS (Electronic Referral Information Sharing System

Referral and Alert Management

ERISS serves to enhance the communications between NWAS and its other key stakeholders to help improve patient care and their integral outcomes.

ERISS is a web application that uses Microsoft .NET technologies. It is written in C#, using the latest MVC and Entity Framework libraries. It runs on two Microsoft Windows Servers running IIS and SQL Server.

How does ERISS work? There are two parts of the system, Referrals and Alerts. If an ambulance crew is called to an incident where, after treatment, the patient does not require transportation to a hospital, a referral form can be completed in ERISS that will be automatically routed to an appropriate care provider. The referral will be securely managed within the system, ensuring that all referrals are followed up, and providing reporting capabilities.

A number of common referral types are provided by the system (e.g. Diabetes, Falls and Safeguarding), each of which will be routed to an appropriate care provider. Operating in the opposite direction, ERISS provides a method for GPs to "Alert" NWAS of the expected medical condition of their patients when responding to an emergency call at their address. Details of conditions such as Chronic Obstructive Pulmonary Disease (COPD) and End of Life Palliative Care can be entered into ERISS, which will prompt NWAS users to update their computer-aided dispatch system, and remind the GP shortly before the alert is due to expire.

Business benefits delivered

As an emergency service, North West Ambulance Service demands a secure and reliable system. ERISS provides a secure central information sharing hub that has delivered the following benefits:

- **The provision of more appropriate care through improved visibility of the interventions across the entire health system;**
- **Reduced demand for specific clinical areas;**
- **Reductions in unnecessary hospital admission, which will clearly help deliver savings.**

A comprehensive programme of enhancements has been operating in parallel with the support activity to provide significant benefit to users over a number of phases, with enhancements going live on a continual basis. These enhancements include: integration of ERISS with the MIG Healthcare Gateway. ERISS is being enhanced to automatically receive Electronic palliative care co-ordination systems (EPaCCS) messages from the MIG via a web service.

For more information on ERISS, please contact Steve Barnard, NWAS Head of Clinical Governance on 07812 304779 or email steve.barnard@nwas.nhs.uk

Appendix O

Unified Do not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy Audit Tool

100% compliance required for shaded area					
	DNACPR Form Question	Yes	No	Not recorded	Comments (for e.g. no address, illegible, what's missing? If no, why? etc)
1	Are there clear patient details?				
2	Is the date of DNACPR decision completed?				
3	What reason for DNACPR decision has been completed 1a				
	1b				
	1c				
4	Has more than 1 reason been ticked?				
5	If section 1a has been ticked, is there **CLEAR** and **APPROPRIATE** information regarding why the decision has been made?				
6	Has the person been informed of the decision?				
7	If the person has not been informed has a relevant other?				
8	Who has made the decision? GP				
	Consultant				
	Accredited Nurse				
	Other				
9	Is the record clearly dated, timed and signed correctly?				
10	Has the decision been verified (Acute Trusts Only) if appropriate?				
11	Have the following sections been completed? Section 3 - Review				
	Section 4 - Who has been informed				
	Section 5 – Other important information				

	Person's Notes Question	Yes	No	Not recor	Comments (If no or not recorded, why?)
1	Was the form initiated in your organisation?				
2	Is the decision documented in the person's notes?				
3	Are the notes clearly dated, timed and signed correctly?				
4a	Is there evidence of discussion?				
4b	Who was it discussed with? Person				
	Relevant other				
4c	If there is no evidence of discussion, is there evidence of why decision was not discussed with the person?				
5	Is there evidence since the DNACPR decision has been made, that CPR has been carried out?				
6	Is there evidence of a mental capacity assessment?				