

# **Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy**

Developed in conjunction with:

North West Ambulance Service NHS Trust, Cheshire and Merseyside Strategic Clinical Network,  
Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks

**Policy Development:**

North West Regional UDNACPR  
Steering Group

**Policy Approval:**

Hill Dickinson (On behalf of NHS  
England, (North), NWAS, Cheshire  
and Merseyside, Greater  
Manchester South Cumbria and  
Lancashire Strategic Clinical  
Networks

**Approval Date:**

27th October 2014

**Version Number:**

1.4

**Date of Development:**

August 2012

**Date of Issue:**

31st October 2014

**Review Date:**

April 2015

**Policy Lead**

Chair, North West Regional  
UDNACPR Steering Group

## CHANGE RECORD FORM

Version	Date of Change	Date of Release	Changed By	Reason for Change
X0.1	30/08/2012		Steve Barnard	Document development. Legal review and Approval of policy NHS England
1.0		01/01/2013	Steve Barnard	Release of Policy
1.1	24/09/2013		Maria Kane	Inclusion of Review date and Change control form for version control
1.2	25/11/13	25/11/13	Steve Barnard	Finalisation of policy amends.
1.3	16/07/2014		Maria Kane	Amendments to policy to include appendices for MCA Guidance and review due to Court of Appeal ruling.
1.4	05/08/2014	31/10/2014	Maria Kane	Amendments to the policy in line with legal scrutiny ( Hill Dickinson) and sign off from review group

# NORTH WEST UNIFIED DNACPR ADULT POLICY

## Contents

1. Introduction .....	5
2. Policy Statement .....	5
3. Purpose .....	7
4. Scope .....	7
5. Definitions .....	7
6. Legislation and Guidance .....	9
7. Roles and Responsibilities .....	9
8. Process .....	11
▪ Documenting and communicating the decision	
▪ Confidentiality	
▪ Discharge/ Transfer procedure	
▪ Cross Boundaries	
9. Review .....	18
10. Situations where there is lack of agreement .....	18
11. Cancellation of a DNACPR Decision.....	19
12. Suspension of a DNACPR Decision .....	19
13. Audit .....	19
14. References.....	20
15. Acknowledgement .....	21
Appendix 1: .....	22
Appendix 2: .....	25
Appendix 3: .....	29
Appendix 4: .....	31

## **1. INTRODUCTION**

- 1.1 This policy must only be used by individuals who are trained and competent in the application of the Mental Capacity Act (2005) ("MCA") and in full accordance with organisational MCA policy and related guidance or procedures. (See appendix 4)
- 1.2 The chance of survival following Cardiopulmonary Resuscitation (CPR) in adults is relatively low depending on the circumstances. Although CPR can be attempted on any person, there comes a time for some people when it is not appropriate to do this. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity. This policy should be read and applied in conjunction with the MCA.

## **2. POLICY STATEMENT**

The North West Unified Adult DNACPR policy will ensure the following:

- 2.1 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; Or
  - A personal welfare attorney ("PWA"), appointed by the patient to make life-sustaining treatment decisions when s/he lacks the capacity to do so themselves, has refused consent to CPR.
- 2.2 Please note if there is clear evidence of a recent verbal refusal of CPR whilst the person had capacity then this should be carefully considered when making a best interests decision. Good practice means that the verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make a written ADRT, complying with the requirements of the MCA, to ensure the verbal refusal is adhered to.
- 2.3 There will be some patients for whom attempting CPR is inappropriate; for example, a patient who is at the end stages of a terminal illness. In these circumstances CPR would not restart the heart and breathing of the individual, and should therefore not be attempted. The patient and/or relatives/carers should be informed of this.
- 2.4 All DNACPR decisions must be based on current legislation and guidance.
- 2.5 In patients where cardiac arrest might be expected to occur and where it is expected that there is a reasonable chance of success of CPR then the patient should be asked whether they would want it to be performed. The patient may ask for family or friends to be involved in the decision.
- 2.6 If the patient lacks mental capacity to take part in the discussion and make decisions then the relatives, others close to the patient and recognised carers should be asked if the patient had made a previous decision about resuscitation. All discussion and subsequent

decisions should be accurately and clearly documented. Patients, family or friends have a right to refuse to take part in the discussions.

- 2.7 A standardised form for adult DNACPR decisions will be used (See Appendix 1).
- 2.8. Effective communication concerning the individual's resuscitation status will occur among all members of the multidisciplinary healthcare team involved in their care and across the range of care settings. This should include carers and relatives where appropriate.
- 2.9 Patients have a right, under Article 8 of the European Convention on Human Rights, to have DNACPR decisions explained to them by care staff, and be consulted / informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. Clinicians have a legal duty to consult the patient. The fact that the patient may find the topic distressing is not a sufficient reason on its own to warrant their exclusion. Such exclusion will only be justified where there are reasonable grounds to believe that the discussion will cause the patient a degree of physical or psychological harm. Where this view is reached, clear and comprehensive reasons for excluding the patient from the discussions, and the decision to make a DNACPR order should be recorded.
- 2.10 Where a patient lacks capacity under the MCA to make decisions regarding DNACPR, there is a duty to consult with the patient's family and those close to the patient, unless there is a good reason not to do so (e.g., the patient has previously, when he/she had capacity, requested that no such discussion take place). Where a patient who lacks capacity has no one close to them with whom health professionals can consult, and decisions are being made about serious medical treatment (such as the implementation of a DNACPR order), a referral should be made to the local Independent Mental Capacity Advocacy service for an IMCA to be appointed for the patient. In such cases, the role of the IMCA is to check that the best interests principle has been followed ensure that the person's wishes and feelings have been appropriately considered and to seek a second opinion if necessary. The input of an IMCA may not be available immediately and, if urgent decisions are required to be made before the involvement of an IMCA can be arranged then they should be made in accordance with the patient's best interests; the referral process should not prevent appropriate care planning taking place whilst the input of an IMCA is awaited. However, any decisions made prior to the IMCA's involvement should be reviewed following receipt of the IMCA's report. Information provided by the IMCA must be taken into account when considering a patient's best interests.
- 2.11 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. 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.
- 2.12 The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.
- 2.13 Training at a local/regional level will be available to enable staff to meet the requirements of this policy.

- 2.14 This policy has been reviewed by NHS England (North) legal advisers to ensure it provides a robust framework underpinned by relevant national guidance and legislation. Organisations adopting this policy should also ensure it is reviewed by their local legal services.

### 3. PURPOSE

3.1 This policy will provide a framework to ensure that DNACPR decisions:

- Respect the wishes of the individual, where possible
- Reflect the best interests of the individual
- Provide benefits which are not outweighed by burden.

3.2 This policy will provide clear guidance for health and social care staff.

3.3 This policy will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the individual's care or treatment options.

### 4. SCOPE

4.1 This policy where adopted, applies to all of the multidisciplinary health, social and tertiary care teams involved in patient care across the range of settings within the North West area.

4.2 This policy is applicable to all individuals aged 18 and over.

4.3 This policy forms part of Advance Care Planning for patients and should work in conjunction with end of life care planning for individuals.

### 5. DEFINITIONS

5.1 **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.

5.2 **Cardiac Arrest (CA)** is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal gasping respiration. In simple terms, cardiac arrest is the point of death.

5.3 **Respiratory Arrest** is the cessation of normal respiration due to failure of the lungs to contract effectively.

5.4 The **Mental Capacity Act 2005 (MCA)**, was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards. (See Mental Capacity Act Guidance in appendix 4)

5.5 **Mental Capacity:** An individual aged 16 (between 16-18 years are treated under the Children and Young person's Advance Care Planning Policy) or over is presumed to have

mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals will lack capacity if they are suffering from an impairment of, or disturbance in, the functioning of the mind or brain and are unable to demonstrate that they can do any of the following:

- understand information relevant to the decision provided to them in the most appropriate way for the individual; or
- retain that information for long enough to make a decision; or
- use or weigh that information as part of the process of making the decision; or
- communicate the decision, whether by talking or sign language or by any other means.

- 5.6 **Advance Decision to Refuse Treatment (ADRT):** The MCA provides the framework for people aged 18 or over to make an ADRT and confirms the requirements that must be met to ensure that it is valid and applicable. An ADRT is a decision by an individual to refuse a particular treatment in the future should they lose capacity to make the decision at that time. A valid and applicable ADRT is legally binding. In order for an ADRT relating to refusal of life-sustaining treatment, such as CPR, to be valid, it must: 1) be in writing; 2) be signed by the patient; 3) be witnessed and signed by the witness; and 4) include a statement that it is to apply even where the patient's life is at risk. The clinical team must also be satisfied that there is no evidence that the patient has withdrawn their decision since making it or done anything clearly inconsistent with its terms.
- 5.7 **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** refers to a decision not to make efforts to restart breathing and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotics etc.
- 5.8 **Lasting Power of Attorney (LPA):** The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to make a LPA by appointing a Personal Welfare Attorney (**PWA**) who can make decisions regarding health and wellbeing on their behalf once capacity is lost. Note – Not all PWAs have authority to make life-sustaining treatment decisions. All LPA documentation should be checked and, if in doubt, contact should be made with the Office of the Public Guardian to clarify the validity of the LPA.
- 5.9 **Independent Mental Capacity Advocate (IMCA):** An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them. They must be consulted when a decision about either serious medical treatment or a long term move is being made.
- 5.10 A **Court Appointed Deputy** is appointed by the Court of Protection, to make decisions in the best interests of those who lack capacity but they cannot make decisions relating to life-sustaining treatment.
- 5.11 **Health and Social Care Staff:** Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.

## 6. LEGISLATION AND GUIDANCE

### 6.1 Legislation

6.1.1 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.

6.1.2 The following provision of the Human Rights Act 1998 are relevant to this policy:

- the individual's right to life (article 2)
- to be free from inhuman or degrading treatment (article 3)
- respect for privacy and family life (article 8)
- freedom of expression, which includes the right to hold opinions and receive information (article 10)
- to be free from discriminatory practices in respect to those rights (article 14).

6.1.3 Clinicians have a professional duty to report some deaths to the Coroner and should be guided by local practice as to the circumstances in which to do so but must always report when the deceased has died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.

For more information see:

Coroners, post-mortems and inquests: Directgov - Government, citizens and rights

<http://www.direct.gov.uk>

6.1.4 Each organisation who implements this policy requires the completion of an Equality Impact Assessment (EIA); each organisation will need to carry out an EIA in line with their organisational policy.

## 6.2 Guidance

6.2.1 The Resuscitation Council (UK):

- Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
- Decisions Relating to Cardiopulmonary Resuscitation – Resuscitation Guidelines 2010.
- Decisions relating to cardiopulmonary resuscitation, October 2014 (3<sup>rd</sup> edition)

<http://www.resus.org.uk>

## 7. ROLES AND RESPONSIBILITIES

7.1 This policy and its forms/ appendices are relevant to all health & social care staff across all settings of care including primary, secondary, independent, ambulance and voluntary sectors who have adopted the policy. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed by the local authority or employed privately by an agency.

7.2 The decision to complete a DNACPR form should be made by a Consultant/ General Practitioner (or Doctor who has been delegated the responsibility by their employer / Registered nurse who has achieved the required competency). Registered nurses must complete the recognised competency training designed by each organisation and be

indemnified by their organisation. Organisations must ensure that a DNACPR decision is verified by a professional with overall responsibility at the earliest opportunity.

7.3 Health and social care staff should encourage the individual or their representative, where able, to inform those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

7.4 The Chief Executive of each organisation is responsible for:

- ensuring that this policy adheres to statutory requirements and professional guidance
- supporting unified policy development and the implementation in other organisations
- ensuring that the policy is monitored
- reviewing the policy, form and supporting documentation every two years
- compliance, both clinical and legal with the regional policy and procedure
- ensuring the policy is agreed and monitored by the organisation's governance process

7.5 Directors or Managers responsible for the delivery of care must ensure that:

- staff are aware of the policy and how to access it
- the policy is implemented
- staff understand the importance of issues regarding DNACPR
- staff are trained and updated in managing DNACPR decisions
- the policy is audited and the audit details are fed back to a nominated Director
- DNACPR forms, leaflets and policy are available as required.

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.

7.7 A registered nurse making DNACPR decisions must:

- be competent to make the decision (see 7.2)
- document the decision (See 8.6.1)
- 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.

7.8 Health & social care staff delivering care must:

- 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 decision or an ADRT on the transfer of a person
- participate in the audit process.

7.9 Ambulance staff must ensure they adhere to the policy including relevant organisational policies, procedures and guidance.

7.10 Commissioners and provider organisations must ensure:

- that commissioned services implement and adhere to the policy and procedure as per local contracts
- that pharmacists, dentists and others in similar health and social care occupations are aware of this policy
- that DNACPR education and training is available and provided. This should be the subject of regular audit
- audit of provider organisations' compliance with regional DNACPR paperwork, record of decision making, and any complaints/ clinical incidents involving the policy.

## **8. PROCESS**

8.1 For the majority of people receiving care in a hospital or community setting, the likelihood of cardiopulmonary arrest is small; therefore no discussion of such an event routinely occurs unless raised by the individual.

8.2 In the event of an unexpected cardiac arrest, CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless:

- a valid DNACPR decision or an ADRT is in place and made known (NB – where there is recorded evidence that a patient has clearly expressed that he/she would not wish to receive CPR but has not made a formal ADRT which meets the requirements under the MCA, it is nonetheless important to consider the patient's wishes. In such circumstances, it is unlikely that it would be appropriate to perform CPR. However, if there is any doubt as to whether the patient's views remain the same, the balance lies in favour of preserving life).
- A PWA who has the authority to make the decision is present at the point of the arrest. This individual will then make the decision regarding commencement and/or discontinuation of CPR
- It is concluded, having considered all necessary factors under the best interests checklist, that it is not in the patient's best interests.

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

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

8.4 In the event of registered health care staff finding a person with no signs of life and clear clinical signs of prolonged death, and with no DNACPR decision or an ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR (Some organisations may define other health care staff within this section). Consideration of the following will help to form a decision, based on their professional judgement which can be justified and later documented:

- What is the likely expected outcome of undertaking CPR?
- Is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading?
- Is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interests decision on behalf of the patient
- Provided the registered health care staff has demonstrated a rationale for their decision-making, the employing organisation will support the member of staff if this decision is challenged.

8.5 The decision-making framework is illustrated in Diagram 1 on page 16. When considering making a DNACPR decision for an individual it is important to consider the following:

- Is cardiac arrest a clear possibility for this individual? If not, it may not be necessary to go any further
- If cardiac arrest is a clear possibility for the individual, and CPR may be successful, will it be followed by a length and quality of life that would not be of overall benefit to the person? The person's views and wishes in this situation are essential and must be respected.
- If the person lacks capacity, check whether they have made a valid and applicable ADRT or have appointed a PWA with appropriate authority. If so, follow this decision or consult with the PWA accordingly. If a PWA for personal welfare has not been appointed a best interests decision will be made. In making a best interest decision, the health professional must seek the views of those interested in the welfare of the patient, such as the patient's family and close friends, or an appointed IMCA (where a patient is "unbefriended" and has no one else, other than paid professionals, for the treating team to consult with).
- If the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death. The patient should be informed of the DNACPR decision unless they will clearly be harmed by this information; in which case the rationale for not discussing it should be fully documented. Please note that the fact such a conversation may be distressing for the patient is not sufficient to justify their exclusion from the process. The distress must be likely to cause the patient a degree of harm to warrant them not having the

decision discussed with or explained to them. If this is the case, you should seek their agreement to share relevant information with those close to them (such as relatives and carers) so that they may support the person's treatment or care. If the person wishes for this information to remain confidential, this should be respected and recorded within their notes. Where the patient lacks capacity, those close to the patient should be informed of a DNACPR decision unless there is a good reason not to. Please note, it is only in very rare circumstances that a DNACPR decision should be placed in a patient's notes without the patient and/ or their family being informed. The reasons for doing so should be fully documented.

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

- the DNACPR decision is made following discussion with patient/others, this must be documented in their notes
- the DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this. If you conclude that the patient does not wish to know about or discuss the 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 discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, this must be clearly documented in their notes
- the DNACPR information leaflet (See Appendix 2) should be made available where appropriate to individuals and their relatives or carers. It is the responsibility of each individual organisation to ensure that different formats and languages can be made available
- the DNACPR decision is required for a person who lacks capacity to assist in the decision making process. This decision must be discussed with friends/family and their views taken into consideration when making a best interest decision. For those who have no one to consult with an IMCA referral must be made.

## 8.7 Documenting and communicating the decision

8.7.1 Once the decision has been made, it must be recorded on the North West Adult DNACPR form (See Appendix 1) and written in the person's notes.

8.7.2 The **LILAC** form must stay with the person at all times:

- The person's full name, NHS or hospital number, date of birth, date of writing decision, review date if applicable 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
- In an inpatient environment e.g. hospitals, Specialist Palliative Care in-patient units, 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
- For deceased people – lilac and one white copy stay in medical notes and one white copy is retained for audit purposes
  - For people in their homes:
    - The lilac form is placed in their home
    - a white copy remains in their notes at the GP's surgery (ensure that the DNACPR decision is recorded in the individual's electronic problem list using the appropriate Read Code) and;
    - the third white copy is retained for audit purposes.
  - Where 'message in a bottle' schemes exist, the tear-off slip on the lilac form may be completed and placed in the "message in a bottle" in the person's refrigerator. The location of the DNACPR form needs to be clearly stated on the tear off slip (e.g. my form is located in the nursing notes in the top drawer of the sideboard in the dining room). If a "message in a bottle" is not available, a system must be put in place to ensure effective communication of the DNACPR forms location to all relevant parties including the ambulance service  
<http://www.lionsmd105.org>

*Please note:*

- Where the form has been initiated in another institution it will only be the lilac copy that will be in the front of the care notes
- If using an electronic North West Adult DNACPR form ensure one copy is printed on lilac paper, signed and given to the person. A second copy needs to be stored for audit purposes
- If using the North West Adult DNACPR pad ensure that the lilac copy remains with the person and the white copy is retained for audit purposes
- Information regarding the background to the decision, the reasons for the decision, those involved in the decision and a full explanation of the process, must be recorded in the individual's notes, additionally these can be recorded in care records, care plans etc.

**8.7.3 Confidentiality:** If the individual has the mental capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity, and their views on involving family and friends are not known, health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individual's care and is not contrary to their interests.

**8.7.4** It is the health care staff's responsibility to ensure communication of the form to other relevant organisations. The use of an end of life care register is recommended to ensure communication of the decision across settings. It is recommended where the person is at home, the ambulance service is informed, using their warning flag procedure.

## 8.8 Discharge/ Transfer process

8.8.1 Prior to discharge, the person, or relevant other if the person lacks capacity, **MUST** be informed of the DNACPR decision. If the person is competent and it is considered that informing them of the decision would not be likely to cause them harm then this should be sensitively done. The same approach should be taken towards discussion with family members.

8.8.2 If such discussion is likely to cause the patient harm then it is usually impossible to place a DNACPR form in the person's home.

8.8.3 When transferring the person between settings all staff involved in the transfer of care of a person need to ensure that:

- the receiving institution is informed of the DNACPR decision and provided with the patient's lilac DNACPR Form on arrival
- where appropriate, the person (or those close to the person if they lack capacity) has been informed of the DNACPR decision
- the decision is communicated to all members of the health and social care teams involved in the person's ongoing care
- the decision has been documented on the end of life care register
- the ambulance service has been informed via the warning flag procedure.

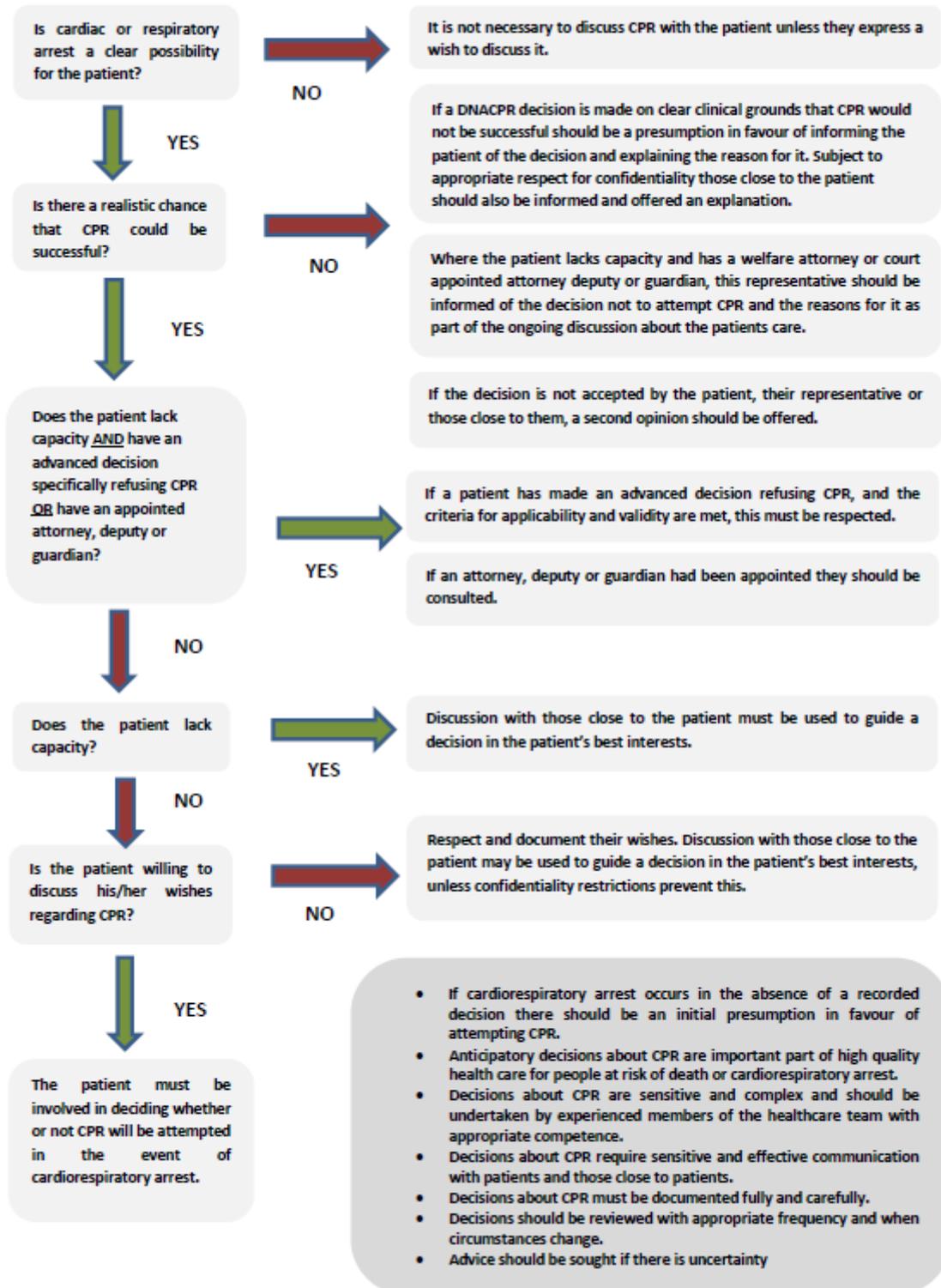
**Ambulance transfer:** If discussion has taken place regarding deterioration during transfer the 'Other Important Information' section must be completed by any health care staff, stating; the preferred destination (this cannot be a public place), the name and telephone number of next of kin or named contact person. If there are no details and the patient is being transferred, should they deteriorate, they will be taken to the nearest Emergency Department.

**Non ambulance transfer:** other organisations transferring patients between departments, other healthcare settings and home should be informed of, and abide by, the DNACPR decision, subject to any change in circumstances.

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.

8.8.5 **Cross Boundaries:** If a patient is discharged from an institution that does not use the North West Adult DNACPR form, providing their form is agreed following clear governance and legal process, it will be recognised by health and social care staff, until a time that the information is transferred onto the North West Adult DNACPR form. Therefore, a patient who lives on the North West borders may have 2 forms, (i.e. NHS North of England Deciding Right DNACPR), depending on where they go in the region. Whenever a patient comes back into the North West region, the original form is replaced in the patient's notes or a new form written if the original is not available.

## Decision Making Framework



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 3<sup>rd</sup> Edition, October 2014

## **9. REVIEW**

9.1 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.

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

## **10. SITUATIONS WHERE THERE IS LACK OF AGREEMENT**

10.1. A person with mental capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an ADRT. An ADRT is a legally binding document which has to be adhered to. It is good practice to have a DNACPR form with the ADRT but it is not essential.

10.2 Please note if the person had capacity prior to arrest, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. The verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make an ADRT to ensure the verbal refusal is adhered to (See Mental Capacity Act Guidance in appendix 4)

10.3 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. In such circumstances, a comprehensive discussion with the patient should be held in order to better understand the reasons for their views. A second opinion may assist in reaching agreement. Individuals do not have a right to demand that doctors carry out treatment against their clinical judgement. However, generally, where a patient requests for CPR to be attempted then their wishes should be respected, except in extreme cases where the clinicians are clear that it would not work and providing it would be deemed unethical. In all such cases, legal advice should be sought before a DNACPR order is implemented.

## 11. CANCELLATION OF A DNACPR DECISION

- 11.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point ink and the word '**CANCELLED**' written clearly between them, dated, signed and name printed by the health care staff. The cancelled form is to be retained in the person's notes. **It is the responsibility of the health care staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision.**
- 11.2 Electronic versions of the DNACPR decision must be cancelled with two diagonal lines and the word '**CANCELLED**' typed between them, dated, signed and name printed by the health care staff.
- 11.3 On cancellation or death of the person at home, if the 'ambulance service warning flag' has been ticked on section 4 of the form, the health and social care staff dealing with the person, **MUST** inform the ambulance service that cancellation or death has occurred.

## 12. SUSPENSION OF DNACPR DECISION

- 12.1 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.
- 12.2 Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation, such as anaphylaxis or choking. CPR would be appropriate while the reversible cause is treated.
- 12.3 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. Discussion with key people, including the person if appropriate, will need to take place.

## 13. AUDIT

- 13.1 Individual organisations will measure, monitor and evaluate compliance with this policy through audit and data collection using the Key Performance Indicators.
- 13.2 All organisations will have clear governance arrangements in place which indicate individuals and Committees who are responsible for this policy and audit. This includes:
- data collection
  - ensuring that approved documentation is utilised
  - managing risk

- sharing good practice
- monitoring of incident reports and complaints regarding the DNACPR process
- developing and ensuring that action plans are completed

### 13.3 Frequency:

- compliance with the policy will be audited annually using the DNACPR Audit Tool (See Appendix 3)
- local leads will decide the number of DNACPR forms to be examined
- All institutions must store the audit copy of the DNACPR form so that it is easily accessible when the local lead requests the information.

13.4 Information will be used for future planning, identification of training needs and for policy review.

## 14. REFERENCES

Advance Decisions to Refuse Treatment, a guide for health and social care professionals. London: Department of Health <http://www.ncpc.org.uk/download/publications/ADRT.pdf> [Accessed 03-06-2009]

Coroners and Justice Act 2009 London: Crown Copyright. <http://www.legislation.gov.uk/ukpga/2009/25/contents> [Accessed 12/10/2009]

General Medical Council (2010) Treatment and care towards the end of life: good practice in decision making Guidance for doctors. [http://www.gmc-uk.org/static/documents/content/End\\_of\\_life.pdf](http://www.gmc-uk.org/static/documents/content/End_of_life.pdf) [Accessed 03-09-2010]

Human Rights Act. (1998) London: Crown Copyright. [http://www.opsi.gov.uk/acts/acts1998/ukpga\\_19980042\\_en\\_1](http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1) [Accessed 03-06-2009]

Mental Capacity Act. (2005) London: Crown Copyright. [http://www.opsi.gov.uk/acts/acts2005/ukpga\\_20050009\\_en\\_1](http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1) [Accessed 03-06-2009]

NHS End of Life Care Programme & the National Council for Palliative Care (2008)

Resuscitation Council UK (2007) Decisions relating to cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. RC (UK) <http://www.resus.org.uk/pages/dnar.pdf> [Accessed 03-06-2009]

Royal College of Physicians (2009) Advance Care Planning. London: Royal College of Physicians <http://www.rcplondon.ac.uk/pubs/contents/9c95f6ea-c57e-4db8-bd98-fc12ba31c8fe.pdf> [Accessed 03-06-2009]

## **15. ACKNOWLEDGEMENT**

NHS - North West would like to thank South Central SHA and Tracey Courtnell (Senior Resuscitation Officer / Project Manager SCSHA uDNACPR) for sharing their experience, collaboration and allowing us to adapt their policy.

# APPENDIX 1

## **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](http://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**

<b>1.</b>	<b>Reason for DNACPR decision</b>	
<b>1.A</b>	<b>CPR is unlikely to be successful</b>	Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person's best interests. 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.
<b>1.B</b>	<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</b>	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.
<b>1.C</b>	<b>DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.</b>	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.
<b>2.</b>	<b>Person making this DNACPR decision/ Verification</b>	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.
<b>3.</b>	<b>Review</b>	All decisions should be regularly re-assessed at appropriate intervals; such as (if patient's 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.
<b>4.</b>	<b>Who has been informed of this DNACPR decision?</b>	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.
<b>5.</b>	<b>Other Important Information</b>	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.
	<b>Tear off slip</b>	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.'



## **APPENDIX 2**

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



September 2014 Version 1.1



**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.

#### **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.

4

#### **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.

5

#### **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.

6

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](http://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.

7

**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 your 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.

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 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

## **Appendix 3**

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

100% compliance required for shaded area					
	<b>DNACPR Form</b> 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 <b>CLEAR</b> and <b>APPROPRIATE</b> information regarding why the decision has been made?				
6	Has the person been consulted about / 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				
	<b>Person's Notes</b> Question	Yes	No	Not recorded	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?				
7	Where patient lacks capacity, has appropriate consultation taken place with those close to the patient regarding best interests?				

## **Appendix 4**

## 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. Details of where copies of the MCA and its code, along with other useful information, can be found are located at the end of this Appendix.

### **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)?

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 (eg, 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:**

<b>ADRT</b>	<a href="http://www.adrtnhs.co.uk">www.adrtnhs.co.uk</a> <a href="http://www.ncpc.org.uk/download/publications/ADRT.pdf">www.ncpc.org.uk/download/publications/ADRT.pdf</a>
<b>Human Rights Act 1998</b>	<a href="http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1">www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1</a>
<b>MCA</b>	<a href="http://www.legislation.gov.uk/ukpga/2005/9/contents">www.legislation.gov.uk/ukpga/2005/9/contents</a>
<b>MCA Code of Practice</b>	<a href="http://www.publicguardian.gov.uk/mca/code-of-practice.htm">www.publicguardian.gov.uk/mca/code-of-practice.htm</a>