

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.'

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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 - Sept 2014

UDNACPR NW

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Name: Address: Post code: Date of birth: / / NHS or hospital number: <input type="text"/>	Date of DNACPR Decision / /  Institution Name Form completed electronically? Yes <input type="checkbox"/> No <input type="checkbox"/> Consent Has the patient consented to share this decision with other Health Care Professionals? Yes <input type="checkbox"/> No <input type="checkbox"/> Before completing this form, please see explanation notes
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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 <input type="checkbox"/> No <input type="checkbox"/>
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Name:	Position:	GMC/NMC:
Signature:	Date: / /	Time: :

4. Who has been informed of this DNACPR decision?

Please Tick

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.

Name: Address: Post code: Date of birth: / / NHS or hospital number: <input type="text"/>	The DNACPR form is located: <div style="background-color: #cccccc; padding: 5px; text-align: center;"> Important: this form MUST be printed on lilac paper </div>
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