

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Cardiopulmonary Resuscitation: Decision Making Policy

Effective: April 2010

Review Date: April 2013

1. Scope and Foundation

This policy relates only to cardiopulmonary resuscitation in adults and not to any other treatment limitation or withdrawal decisions.

This policy takes into account the joint statement from the British Medical Association, the Resuscitation Council, and the Royal College of Nursing (2001) and the Standards for Clinical Practice and Training document (the Royal College of Physicians, Royal College of Anaesthetists, the Intensive Care Society and the Resuscitation Council, 2004) in addition to Guidance from the General Medical Council.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders are advisory documents and clinical judgement always takes precedence. Valid and applicable written advanced decisions to refuse treatment (ADRT) are legally binding and an accompanying DNACPR would be similarly binding.

2. Existing DNACPR orders from other organisations.

At present all DNACPR orders are Trust-specific and if a patient moves between Trusts the DNACPR order will automatically lapse and must be reviewed and re-instituted if appropriate each time a patient is admitted to the NUTH Trust. This includes the DNACPR policies of the Northumbria Ambulance services. Any existing policy from NUTH will automatically lapse when the patient is discharged from the Trust. ADRT orders remain active regardless of the patient's location and do not need re-signing, but associated DNACPR forms will need to be renewed for each admission.

3. Circumstances where a DNACPR order should NOT be considered

If there is **not** a predictable risk of cardiorespiratory arrest occurring in the circumstances of the patient during their current admission then you should NOT fill out a DNACPR form. If an arrest occurs unexpectedly then the circumstances of that arrest need to be assessed to determine whether CPR is appropriate based on the immediate clinical situation at the time of the arrest. The clinician attending the patient at that time must make that decision. If there is doubt then a 2222 call should be made and CPR should be commenced. With the current format a DNACPR form has a binary nature: either do, or do not, there are no maybes. Therefore to fill it out there must be no possibility of a reversible arrest occurring which with CPR could have a successful outcome for the patient (for patients with valid Advanced Decisions to Refuse Treatment see below). The situation where attempts at resuscitation are not pursued when the cause of the arrest was readily correctable and was not the envisaged cause of death, (i.e. a blocked tracheostomy tube in a patient who has a pharyngeal cancer but who may have many weeks of quality life left to them) must be avoided.

It is important to understand that the fact that CPR has been commenced does not mean that it must be continued if subsequent information comes to light to suggest it is inappropriate. Similarly even if spontaneous output is regained with resuscitative efforts this does not automatically mean that admission to ITU and full aggressive treatment is appropriate. That decision must be made by experienced critical care medical staff on the basis of prognostic indicators and clinical circumstance.

For a patient with capacity, if there is **not** a predictable risk of cardiorespiratory arrest occurring but the patient has a severe and progressive end stage illness, it may be appropriate to consider discussing an Advanced Decision to Refuse Treatment (ADRT). This form allows a more structured plan to be detailed which may include restriction of attempts at CPR in certain pre-designated circumstances. Only if the ADRT specifically states that the patient would not wish CPR under any circumstances should a DNACPR form be filed in the notes. For all other ADRT aspects the contents of the ADRT order must be made known to all staff caring for the patient. Please refer to the [Trust Advanced Refusal of Treatment](#) policy.

For a patient who lacks capacity, and for whom there is not a predictable risk of cardio-respiratory arrest, any decisions regarding treatment limitation on the basis of quality of life and burdens of treatment must abide by current UK legislation (such as the Mental Capacity Act and the Human Rights Act)

4. Circumstances where a DNACPR order should be considered

- i) There is a predictable risk of cardiorespiratory arrest occurring in the current circumstances of the patient.
- and
- ii) CPR is very unlikely to provide a successful outcome for the patient if they were to arrest,
- or
- iii) CPR could be successful, but a patient with capacity refuses to consent to CPR
- or
- iv) CPR could be successful but potential burdens outweigh benefits: the patient with capacity must give consent (after all implications explained) for a DNACPR order to be completed. If the patient wishes to receive CPR this must be offered, regardless of what the clinicians believe (see section 7 of the 2007 Joint Statement).
- or
- iv) There is a valid and applicable advanced directive specifically precluding attempts at CPR.

5. Seniority of medical staff

A clinical decision that states that attempts at cardiopulmonary resuscitation would not succeed should ideally be made by a Consultant.

In patients in whom an arrest is anticipated and CPR could have a successful outcome but it is decided that CPR would not be appropriate consent for a DNACPR order should be obtained from the patient, ideally by the consultant responsible for the patient.

However, circumstances may dictate that a Specialist Trainee 3 (or above) (ST3+) is the most senior doctor available when decisions need to be made. Completion of a DNACPR form may be performed by any fully registered medical practitioner, with the agreement of an ST3+ or Consultant. In such instances, the decision should be discussed with a Consultant who should countersign the ST3+ signature at the earliest opportunity.

It is inappropriate for F1 or F2 doctors to make DNACPR decisions alone, although they should be involved in discussions (led by a Consultant or ST3+) as part of their training.

6. Pro-active engagement of patients in decision making

It is important to differentiate consent for withholding attempts at CPR from good communication. This consent can only be obtained in one situation- when an arrest is anticipated *and* CPR could be successful. For all other scenarios consent cannot be obtained because an arrest is not anticipated, CPR is not an option, or a previous order has already made the decision (e.g. an ADRT).

However, at every stage good communication is essential. This requires answering any questions the patients may have, and speaking to partners or relatives if the patient with capacity gives permission. There is no requirement to discuss CPR, but there is a requirement to listen to a patient's concerns and answer questions honestly, even if this means being honest that a clear answer does not exist.

Any consent process and communication should be recorded in the notes.

7. Advance Refusals of Treatment

Some patients may have a valid Advance Decision to Refuse Treatment (ADRT) which they may wish to be followed. Where appropriate, staff should enquire whether an ADRT exists and the [Trust Advanced Refusal of Treatment](#) policy should be observed.

8. Legal authority to accept or decline Cardiopulmonary resuscitation

Where a patient has capacity for this decision only the patient is entitled in Law to give or withhold consent for treatment.

See section 5

9. Where a patient lacks capacity

If a patient lacks capacity (as defined in the Mental Capacity Act (MCA) then you must determine if there is a valid ADRT refusing CPR relevant to the current circumstances of the patient, or a signed Welfare Attorney order with Personal Welfare-Lasting Power of Attorney (PW-LPA) (with it's accompanying 3rd part certificate) with the authority to decide on serious medical conditions (You must be certain that this has been registered with the Office of the Public Guardian). In the case of a written, valid and applicable ADRT refusing life-sustaining treatment this is legally binding and must be respected. If a PW-LPA order is in place **and** there is a realistic chance that CPR could be successful in the event of cardiopulmonary arrest then that person **must** be consulted before a DNACPR order can be made.

If a patient lacks capacity and there is no relevant ADRT nor a PW-LPA order **and** there is a realistic chance of CPR being successful then the doctor making the decision must do so in the patients best interests, following the processes stipulated by law, e.g. the Mental Capacity Act. Relatives and close friends, or in the absence of relatives or close friends an Independent Mental Capacity Advocate (IMCA) should be included in discussions if a decision is to be based on the potential burdens and risks of CPR. If you require further Guidance on the involvement of IMCA please refer to the checklist in the Best practice Guidance "[The Involvement of IMCA in Serious Medical Treatment Decision](#)" Appendix 1.

If there is no realistic chance of success from attempts at CPR then it is not a legal requirement to discuss a DNACPR order with the PW-LPA, relatives, friends or an IMCA but it is considered good practice to do so.

10. Patients who opt out of decisions

When a patient makes it clear that s/he does not wish to discuss cardiopulmonary resuscitation, then those wishes should be respected. Under these conditions, the Consultant should make a decision in terms of the best interests of the patient. Relatives may be involved in the discussions to be used in the decision making process, as long as there are no objections from the patient, in order to provide information regarding the likely views of the patient.

11. Involvement of relatives, carers and other professional staff

Relatives usually value being able to be part of the discussions about the resuscitation decision-making process and should be included wherever possible if the patient gives permission.

At present, relatives cannot (in law) make DNACPR decisions in situations where the patient lacks decision making capacity and they should not be put in the situation of feeling they have to, or did, make that decision.

Other members of the team, including nursing and paramedical staff, should be included in the decision making process – in order to ensure that a uniform approach is adopted by the healthcare team.

Much distress may be caused in situations where patients or relatives feel that an inappropriate decision to withhold or attempt resuscitation may have been made. Early communication with both the patient and family should help to avoid these problems.

12. When to attempt Resuscitation

Doctors cannot be required to give treatment contrary to their clinical judgment. However, they should, whenever possible, respect patients' wishes to receive treatment, even in cases where there appears to be a small chance of success or benefit.

Resuscitation should be attempted in all patients unless any of the following exist

- a current “Do Not Attempt Cardiopulmonary Resuscitation” DNACPR order
- a valid and appropriate Advance Decision for Refusal of Treatment which specifically states they do not wish to receive attempts at CPR in the circumstances that gave rise to their arrest
- documentation of their express wishes against CPR in the circumstances that gave rise to their arrest
- a condition making Cardiopulmonary Resuscitation very unlikely to be successful.
- obvious signs that the patient has already died (eg. *rigor mortis*)

The 2007 BMA/RC/RCN Joint Statement has the following statement:

“There will be some patients for whom attempting CPR is clearly inappropriate; for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR decision has been made. In such circumstances, healthcare workers who make a considered decision not to commence CPR should be supported by their senior colleagues and employers.” (Section 5, p7)

Clear documentation of the basis for making these decisions should be recorded in the patient’s notes by the person making the decision.

13. Communication, Recording and Review date

DNACPR orders may only be written by a fully registered medical practitioner, responsible for the patient’s care. If made by a trainee the decision must include consultation with a Specialist Trainee or Consultant and the record should be countersigned at the earliest opportunity by the Consultant.

DNACPR orders must be written in the patient’s medical notes in a clear and unambiguous way, signed and dated, along with the reason for the decision.

Any major change in the patient’s clinical state should prompt an immediate review of their DNACPR status. A planned date for review should be included to allow regular reconsideration of the appropriateness of the decision. The default period to review will be a maximum of 3 months.

The default position is also that if the patient is discharged from the Trust then the DNACPR form will automatically lapse and would need review in the event of re-admission.

All adult patients who have had a DNACPR decision made must have a Trust DNACPR form completed and **filed at the front of the notes**.

Once that form is completed the patient’s e-record front sheet (where available) should be amended to denote that a DNACPR order is in place.

Once the decision is changed/reviewed or the patient is discharged, the front copy should be sent to the Resuscitation Officers for audit purposes and the remaining carbon copy filed in chronological order, in the clinical body of the patient’s notes (spine 2) and e-record must be updated to denote the change accordingly.

A record of such decisions must also be made in the nursing notes, preferably by the named nurse or the most Senior Nurse on duty.

The patient's GP should be notified of DNACPR decisions in the discharge summary along with an invitation to review them in the light of changing circumstances.

It is the responsibility of the Consultant and Senior Nurse to ensure this information is disseminated to all members of the team.

14. Change of Resuscitation Status

Where a DNACPR order is made and subsequently withdrawn on review, the original order in both medical and nursing notes must be suitably annotated to avoid any possibility of error.

15. Training

All clinical staff must be aware of this policy. Additional training can be provided by the Resuscitation Training Officers at CPR training sessions for nursing and medical staff.

16. Monitoring

An annual audit will be undertaken across the Trust by the Resuscitation Training Officer and the Clinical Governance and Risk Department (CGARD) to determine the number of DNACPR orders in place and that the orders have been completed to a high standard.

This report will be completed by the Resuscitation Training Officer and presented to the Trust Resuscitation Committee. The Committee will be responsible for identifying any issues regarding compliance with this policy and will monitor action plans to correct deficiencies until all issues are resolved.

Policy author: Chair of Resuscitation Committee 2010

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

Policy Title:	NUTH Do Not Attempt CPR (DNACPR) policy	Policy Author:	Dr D Cressey (Chair of Resuscitation Committee)
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:	NO	There is no reference to any variance in policy dependent upon any of the listed criteria. Account is taken of any declared and recorded individuals wishes with regards to resuscitation. The guideline is in accordance with the Human Rights Act and the Mental Capacity Act 2005
	<ul style="list-style-type: none"> • Race • Ethnic origins (including gypsies and travellers) • Nationality • Gender • Culture • Religion or belief • Sexual orientation including lesbian, gay and bisexual people • Age • Disability – learning difficulties, physical disability, sensory impairment and mental health problems. 		
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	NA	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	Yes in some cases	The change in policy may result in fewer DNACPR orders being filled out and could potentially lead to a rise in the occurrence of inappropriate attempts at CPR.
4(b).	If so can the impact be avoided?	No	In order to protect against the unacceptable scenario of CPR being denied to a patient in a circumstance where it could potentially benefit them and provide a beneficial outcome the policy needs to be made more restrictive. This is in accordance with recommendations from the BMA/RC/RCN joint statements
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?	No	Extensive discussions have taken place in the Resus committee and with Dr Claud Regnard who is an advisor to the SHA and National committees reviewing DNACPR policy.

Comments: Whilst there were concerns raised at the impact of the changes raised at the Resus committee with respect to comments in section 4a the policy is in keeping with National recommendations	Action Plan due (or Not Applicable):
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Name and Designation of Person responsible for completion of this form: Dr David Cressey Consultant in ITU and Chair of Resus Committee Date: 8.4.2010

Names & Designations of those involved in the impact assessment screening process: Dr Claud Regnard Palliative Care Medicine Consultant, Dr V Robson Consultant ITU, Dr B Fullerton, Karen Rowell Resus Officer.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)