This is an extract from the regional guidance on the circumstances under which a DNACPR order can be considered and what process must be followed.

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

All documentation of DNACPR should be performed on version 17 of the form, which appears at the end of this document. If patients are admitted to Newcastle upon Tyne Hospitals Trust from the community with a completed DNACPR form, this decision should be reviewed within 5 days of admission. Review should also include whether the current version of the form has been completed and if not the form should be re-written on version 17.
Cardiopulmonary resuscitation (CPR) decisions

The success of CPR
The likelihood of success after CPR is strongly dependent on the cause and circumstances:

Poor prognosis factors: The chance of a favourable outcome reduces to below 10% in non-shockable rhythms or when the arrest is not witnessed, and can be below 1%. In children, cardiac arrests outside hospital have survival rates up to 9% but they are often left with neurological damage. In end-stage advanced cancer the success of CPR is less than 1% with survival to discharge close to zero.

Factors associated with a better prognosis: the chance of a good outcome from a cardiac arrest is more likely if the individual was previously well, the arrest was witnessed, treatment started immediately, and they have a shockable rhythm. Median hospital survival rates can be as high as 23%. Even in individuals with a life-limiting illness who are still relatively well CPR can be the right decision for them. In children, respiratory arrest and airway obstruction with a foreign body have much higher success rates.

What do individuals want? What clinicians think individuals want regarding CPR differs from the patients. In one survey of UK cancer adults, 58% wanted to be resuscitated despite being told of the poor survival rates. More older people were willing to accept CPR in 2007 compared with 1995. However, this increasing tendency to favour CPR may be related to over-optimism about its success, in part due to the way CPR is presented in the media. In the presence of incurable conditions, individuals’ priorities are the avoidance of life-sustaining treatment and effective communication. However there is a wide range of preferences. Therefore accurate information and effective communication are key elements when individualising decisions.

Decisions around CPR follow the same principles as planning care in advance:
- Putting the individual at the centre of the dialogue
- Good communication skills
- A professional who never assumes what an individual should know or discuss
- Clear documentation of the decision-making process

CPR can be successful in some situations, but it will be unsuccessful and burdensome in other circumstances

Any CPR decision can only be made through shared decision making with the individual with capacity for CPR decisions or MCA best interests process for those who lack capacity for making CPR decisions

The Deciding right decision-aid app for smartphones and tablets is available on Google Play and the Apple store. It includes advice on CPR decisions.
### Principles of cardiopulmonary resuscitation (CPR) decisions

#### General principles

<table>
<thead>
<tr>
<th>Principle</th>
<th>What this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2014 BMA/RC/RCN Decisions on CPR should be the basis for all CPR policies</td>
<td>This should be the core of any local policy</td>
</tr>
<tr>
<td>Blanket CPR or DNACPR decisions should not exist</td>
<td>Policies that require everyone to have CPR or everyone to be DNACPR are unethical and likely to breach the Human Rights Act.</td>
</tr>
<tr>
<td>DNACPR decisions should be reviewed when the individual transfers to a new setting or circumstances change</td>
<td>Since circumstances and an individual’s condition can change, DNACPR forms should be reviewed, ideally within 24 hours, but no more than 5 days after transfer or when circumstances change.</td>
</tr>
<tr>
<td>An individual’s decision is confidential</td>
<td>Individuals will want healthcare staff to know the decision, but have the right not to inform partners, family or friends.</td>
</tr>
</tbody>
</table>

#### Communication principles

<table>
<thead>
<tr>
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</tr>
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<tr>
<td>The involvement of the individual is the default</td>
<td>The individual decides the pace and nature of the communication using the principles of breaking difficult news, i.e., it is not the professionals role to decide what or how quickly an individual should receive difficult news. The likelihood of distress is not a reason to avoid involving the individual.</td>
</tr>
<tr>
<td>Consent and communication/discussion are not the same</td>
<td>Consent can only be obtained for individuals who are at risk of a cardiac or respiratory arrest and in whom CPR could be successful. Communication should occur with all individuals if the individual wishes this.</td>
</tr>
<tr>
<td>If an individual lacks capacity to make a CPR decision, the decision must comply with the Mental Capacity Act (MCA)</td>
<td>The MCA requires that a minimum 9 point checklist is followed for all serious care decisions. See MCA 1 &amp; 2. This process will include partner and relatives.</td>
</tr>
</tbody>
</table>

#### Documentation principles

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>A written, valid and applicable advance decision to refuse treatment (ADRT) is legally binding but, if CPR is being refused, a DNACPR is also needed</td>
<td>An ADRT can refuse CPR but time is needed to check that it is valid, applicable to the specific circumstances and written. In an emergency requiring immediate treatment, a DNACPR form is also needed to ensure CPR is not attempted.</td>
</tr>
<tr>
<td>Emergency health care plans (EHCPs) are important adjuncts to a DNACPR decision</td>
<td>In many settings the complexity of anticipated emergency treatment requires more detailed documentation and these require EHCPs (see p15). DNACPR decisions are not currently part of an EHCP.</td>
</tr>
<tr>
<td>DNACPR paper originals are currently the default</td>
<td>Documents of decisions made in advance can be flagged on e-records, generated by e-record systems and copies kept for archives, but the paper original must be available for making bedside decisions</td>
</tr>
<tr>
<td>A cancelled DNACPR should be clearly marked ‘cancelled’ or ‘invalid’</td>
<td>The method used to indicate this will be a matter of local preference and practice.</td>
</tr>
</tbody>
</table>
# Principles of cardiopulmonary resuscitation (CPR) decisions

## Bedside decision principles

<table>
<thead>
<tr>
<th>Principle</th>
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</tr>
</thead>
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<tr>
<td>If a DNACPR form is missing, CPR will have to start unless there are signs of <em>rigor mortis</em>, they are in the terminal stages of an irreversible illness or there is a valid and applicable ADRT refusing CPR</td>
<td>If an individual at home has chosen not to tell his family, the individual will need to be made aware that there is a risk that, in the event of a collapse, family will call 999 and a paramedic crew would need to resuscitate if the DNACPR form is missing.</td>
</tr>
<tr>
<td>Clinical judgement takes priority over a DNACPR form (DNACPR forms are only advisory)</td>
<td>The decision to start CPR depends on the clinical judgement of the health professional(s) present at the arrest. If they can justify the decision to resuscitate they should start CPR, even if a DNACPR form is present.</td>
</tr>
<tr>
<td>A presumption in favour of CPR should <strong>not</strong> apply in three situations</td>
<td>In the absence of a DNACPR form an individual should not receive CPR if 1. They have already died, as indicated by the presence of post-mortem changes such as <em>rigor mortis</em>. 2. There is clear evidence that they are in the terminal stages of an irreversible illness. 3. There is a valid and applicable ADRT refusing CPR</td>
</tr>
<tr>
<td>The presence of a DNACPR never absolves healthcare staff from making a bedside decision</td>
<td>At an arrest, the final responsibility for the CPR decision rests with those present at the arrest. In the event of an arrest, healthcare staff must make a bedside decision. If they have doubts they should start CPR unless <em>rigor mortis</em> is present, they know the individual is in the terminal stages of an irreversible illness, or there is a valid and applicable ADRT refusing CPR.</td>
</tr>
<tr>
<td>Clinical staff who start CPR based on their clinical judgement should not be criticised if others feel this was unnecessary.</td>
<td>If the call was inappropriate then reflection and a review of the local system of making care decisions in advance are more appropriate responses.</td>
</tr>
<tr>
<td>If healthcare staff know there is a valid and applicable ADRT refusing CPR they must follow the ADRT</td>
<td>A valid and applicable ADRT has the same legal authority as an individual with capacity refusing CPR.</td>
</tr>
</tbody>
</table>
It is often appropriate to consider CPR in assessing a patient but, if there is no reason to anticipate an arrest, a clinician cannot make a DNACPR decision in advance. A patient with capacity retains the right to refuse CPR in any circumstances.

Consequences:
- The young person or adult with capacity must be given opportunities to receive information or an explanation about any aspect of their treatment. If the individual wishes, this may include information about CPR treatment and its likely success in different circumstances.
- Continue to communicate progress to the individual (and to the partner/family if the individual agrees).
- Continue to elicit the concerns of the individual, partner or family.
- Review regularly to check if circumstances have changed.

In the event of an unexpected arrest: carry out CPR treatment if there is a reasonable possibility of success (if in doubt, start CPR and call for help from colleagues, arrest team or paramedics).

It is likely that the individual is going to die naturally because of an irreversible condition. Consent is not possible since CPR is not an available option, but communication about end of life issues should continue.

Consequences:
- Document the reason why there is no realistic chance that CPR could be successful, e.g. "Deterioration caused by advanced cancer."
- Continue to communicate progress to the patient (and to the partner/family if the patient agrees or if the patient lacks capacity). This explanation may include information as to why CPR treatment is not an option.
- Continue to elicit the concerns of the individual, partner, family or parents.
- Review regularly to check if circumstances have changed.
- To allow a comfortable and natural death effective supportive care should be in place, with access if necessary to specialist palliative care, and with support for the partner, family or parents.
- If a second opinion is requested, this should be respected.

In the event of the expected death, AND (Allow Natural Dying) with effective supportive care in place, including specialist palliative care if needed.

- In children and young people: discuss the options with the person who has parental responsibility.
- In adults: check if there is a valid and applicable Advance Decision to Refuse Treatment (ADRT) refusing CPR, a registered and signed Personal Welfare (Health & Welfare) Lasting Power of Attorney order (with its accompanying third party certificate) with the authority to decide on life-sustaining treatment, or a court appointed deputy is involved. The most recent order takes precedence. Otherwise the decision must be made following the Best Interests process as required by the Mental Capacity Act, with the decision-making process clearly documented. If nobody is available to speak for the individual or there is disagreement amongst the family, appoint an Independent Mental Capacity Advocate (IMCA).

- When there is only a small chance of success and there are questions whether the burdens outweigh the benefits of attempting CPR: the involvement of the individual in making the decision is paramount if they have the capacity to make this decision.

In case of serious doubt or disagreement further input should be sought from a local Clinical Ethics Advisory Group or, if necessary, the courts.

CPR should be attempted unless the individual has capacity and states that they do not want CPR attempted.

- Decisions about CPR can be sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully.
- Decisions should be reviewed regularly and when the circumstances change.
- Advice should be sought if there is any uncertainty over a CPR decision.
This DNACPR decision applies only to CPR treatment where the child, young person or adult is in cardiopulmonary arrest

- In this individual, CPR need not be initiated and the hospital cardiac arrest team or paramedic ambulance need not be summoned
- The individual must continue to be assessed and managed for any care intended for health and comfort - this may include unexpected and reversible crises for which emergency treatment is appropriate
- All details must be clearly documented in the notes

Name: NHS no:
Address: Date of birth:
Postcode: Place where this DNACPR decision was initiated:

GP and practice:

If an arrest is anticipated in the current circumstances and CPR is not to start, tick at least one reason:

- There is no realistic chance that CPR could be successful due to:
- CPR could succeed, but the individual with capacity for deciding about CPR is refusing consent for CPR
- CPR could succeed but the individual, who now does not have capacity for deciding about CPR, has a valid and applicable ADRT or court order refusing CPR
- This decision was made with the person who has parental responsibility for the child or young person
- This decision was made following the Best Interests process of the Mental Capacity Act

YES NO Has there been a team discussion about CPR in this child, young person or adult?
YES NO Has the young person or adult been involved in discussions about the CPR decision?
YES NO Has the individual’s personal welfare lasting power of attorney (also known as a health and welfare LPA), court appointed deputy or IMCA been involved in this decision?
YES NO Has the individual agreed for the decision to be discussed with the parent, partner or relatives?
YES NO Is there an emergency health care plan (EHCP) in place for this individual?

Key people this decision was discussed with.

Details of discussions must be recorded (see box right)

Junior doctor (must have GMC licence plus full registration and agree DNACPR with responsible clinician below before activating DNACPR)

Sign: Name: Status:

GMC no:

Date: Time:

Senior responsible clinician

(If a junior doctor has signed, the senior responsible clinician must sign this at the next available opportunity)

Sign: Name: Status:

GMC/NMC no:

Date: Time:

For those individuals transferring to their preferred place of care

If the individual has a cardiopulmonary arrest during the journey, DNACPR and take the patient to:

The original destination [ ] Journey start [ ] Try to contact the following key person
Name: Status: Tel:

This DNACPR is valid for 12 months from either the date of the initial signing or the last review date

Check for any change in clinical status that may mean cancelling the DNACPR.
Reassessing the decision regularly does not mean burdening the individual and family with repeated decisions, but it does require staff to be sensitive in picking up any change of views during discussions with the individual, partner or family.
Any senior responsible clinician who knows the patient can review the DNACPR decision.

Date review was done Name and signature of reviewer

Review if the patient or persons discussed with ask for a review or whenever the condition or situation changes

Form originally developed by the NHS North East Deciding right initiative