# Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

<table>
<thead>
<tr>
<th>Document Author</th>
<th>Authorised</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Written By:</strong> Senior Resuscitation Officer</td>
<td><strong>Authorised By:</strong> Chief Executive</td>
</tr>
<tr>
<td><strong>Date:</strong> June 2017</td>
<td><strong>Date:</strong> 8th August 2017</td>
</tr>
<tr>
<td><strong>Lead Director:</strong> Executive Director of Nursing and Quality</td>
<td></td>
</tr>
<tr>
<td><strong>Effective Date:</strong> 8th August 2017</td>
<td><strong>Review Date:</strong> 7th August 2020</td>
</tr>
<tr>
<td><strong>Approval at:</strong> Corporate Governance &amp; Risk Sub-Committee</td>
<td><strong>Date Approved:</strong> 8th August 2017</td>
</tr>
<tr>
<td>Date of Issue</td>
<td>Version No.</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>29 Mar 12</td>
<td>1.0</td>
</tr>
<tr>
<td>22 Nov 12</td>
<td>1.1</td>
</tr>
<tr>
<td>14 Dec 12</td>
<td>1.1</td>
</tr>
<tr>
<td>17 Dec 12</td>
<td>2.0</td>
</tr>
<tr>
<td>28 Oct 15</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td>18 Dec 15 – 15 Jan 16</td>
<td>2.2</td>
</tr>
<tr>
<td>29 Jan 16</td>
<td>2.2</td>
</tr>
<tr>
<td>09 Feb 16</td>
<td>3.0</td>
</tr>
<tr>
<td>June 2017</td>
<td>3.1</td>
</tr>
<tr>
<td>28 Jul 17</td>
<td>3.1</td>
</tr>
<tr>
<td>08 Aug 17</td>
<td>4.0</td>
</tr>
<tr>
<td>24 Jun 19</td>
<td>4.1</td>
</tr>
</tbody>
</table>

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust
## Contents

1. Executive Summary ................................................................. 4  
2. Introduction ............................................................................ 4  
3. Definitions .............................................................................. 5  
4. Scope ...................................................................................... 6  
5. Purpose .................................................................................. 6  
6. Legislation and Guidance ........................................................ 6  
7. Roles and Responsibilities ........................................................ 7  
8. Policy detail/Course of Action ................................................... 8  
9. Consultant / GP / GP Registrar Verification and Review ............... 12  
10. Situations where there is lack of agreement .............................. 13  
11. Temporary suspension of a DNACPR decision ............................ 13  
12. Consultation .......................................................................... 14  
13. Training .................................................................................. 14  
14. Monitoring Compliance and Effectiveness ............................... 14  
15. Links to other Organisational Documents ................................ 15  
16. References ............................................................................. 15  
17. Appendices ............................................................................ 16
1 Executive Summary

1.1 This policy outlines the process of considering, discussing and placement of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions within the Isle of Wight NHS Trust.

1.2 This policy clearly outlines members of staff roles and responsibilities in the process of considering, discussing and placing DNACPR decisions.

1.3 The Trust has developed its own Ceiling of Treatment and Resuscitation Decision Form, in a move away from the previous Unified DNACPR form reflecting a national trend of other Trusts doing the same. This project has brought together some of the different forms used in End of Life planning.

1.4 The Trust recognises the work currently underway nationally to standardise DNACPR forms and recording of decisions and will review the recommendations of this project when published.

1.5 Compliance with this policy will be monitored monthly.

2 Introduction

2.1 The primary goal of healthcare is to benefit patients by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, leads to more harm or burden than benefit (from the patients perspective), ceases to benefit the patient, or if an adult with capacity has refused treatment, that treatment is no longer justified (BMA, RC (UK), RCN, 2014).

2.2 Prolonging a person’s life usually provides a health benefit to the person. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or the potential harms and burdens of treatment. The decision to use a treatment should be based on the balance of risks and benefits to the individual receiving the treatment. This principle applies to any treatment, including cardiopulmonary resuscitation (CPR) (BMA, RC (UK), RCN, 2014).

2.3 CPR is undertaken in an attempt to restore spontaneous circulation and breathing in a person in cardiac and/or respiratory arrest. CPR is an invasive and traumatic medical intervention and usually includes chest compressions, attempted defibrillation, injections of drugs and ventilation of the lungs.

2.4 The proportion of people who survive cardiorespiratory arrest following CPR is relatively low. In hospital, the chance of surviving cardiorespiratory arrest to discharge varies considerably and depends on many factors, including co-morbidities and the cause and circumstances of the arrest. In hospital the average survival to discharge is in the range of 15-20% (Nolan et al, 2014), out of hospital where resuscitation is attempted, the average survival rate is lower, usually 5-10% (Perkins & Cooke, 2012).

2.5 Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture. In the immediate post-CPR period most people require at least a brief period of observation and treatment in the Intensive Care Unit (ICU) or Coronary Care Unit. Of those who need ICU care, most will require a period of artificial ventilation, and some will require renal dialysis or hemofiltration, and circulatory support with inotropic drugs and/or an aortic balloon pump.
2.6 It is not uncommon for difficult decisions about CPR to arise in people for whom there may be some chance of re-starting their heart after cardiac arrest, but for whom admission to an ICU for continued artificial organ support would be clinically inappropriate because they would be unlikely to survive.

2.7 There is some risk that post resuscitation the person will be left with brain damage/injury resulting in disability, especially if there is a delay between cardiorespiratory arrest and initiation of CPR. The physical aspects of CPR can potentially be traumatic, which may result in the death occurring in a manner that neither the person nor those close to them would have wished (BMA, RC (UK), RCN, 2014).

2.8 CPR could be attempted on any individual who suffers a cardiorespiratory or respiratory arrest. As such events are an inevitable part of dying; CPR could be used on every individual prior to death. It is therefore essential to identify patients for whom cardiorespiratory arrest represents a terminal event in their illness and for whom CPR is inappropriate. In these circumstances it may then be appropriate to consider a defined ceiling of treatment and/or a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision to ensure that if death occurs there is no added loss of dignity. It is also important to identify those patients who would not want CPR to be attempted in the event of death.

3 Definitions

Advanced Decision to Refuse Treatment (ADRT) A decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding.

Cardiopulmonary Resuscitation (CPR) An emergency procedure involving interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs according to the latest guidelines from the Resuscitation Council (UK).

Cardiac Arrest (CA) 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.

Ceiling of Treatment Defines a ceiling of active treatment; such that if there is a failure to respond to that treatment; the patient may require appropriate end of life care.

A Court Appointed Deputy 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.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Refers to not making efforts to restart breathing and/or the heart in the cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotics etc.

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.
Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA) The Mental capacity Act (2005) allows people aged 18 or over, who have capacity, to make an LPA by appointing a PWA who can make decisions regarding health and wellbeing on their behalf once capacity is lost.

Mental Capacity Act 2005 (MCA) The Mental Capacity Act was fully implemented on 1st 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.

Mental Capacity An individual aged 16 years or over is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individual who lack capacity will not be able to demonstrate one of the following:
- Understand information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision
- Communicate the decision, whether by talking or sign language or by any other means.

Staff Anyone who provides care, or who will have direct contact with a person within a healthcare facility. This includes domiciliary care staff.

4 Scope

4.1 This policy applies to all multidisciplinary health and social care staff involved in patient care across the range of settings within Isle of Wight NHS Trust.

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

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

5 Purpose

5.1 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.

5.2 This policy will provide clear guidance for staff.

5.3 This policy will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the individuals care or treatment options.

6 Legislation and Guidance

6.1 Under the Mental Capacity Act (2005), staff are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

6.2 The following sections 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 these rights (article 14).

6.3 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 the Trust’s Reporting Adult Deaths to the Coroner, Completing Death Certificates and Cremation Forms procedure.

6.4 An Equality Impact Assessment (EIA) has been carried out and can be found in appendix 6.

7 Roles and Responsibilities

7.1 This policy and its forms / appendices are relevant to all multidisciplinary health and social care staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. 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 Overall responsibility for making a DNACPR decision rests with the Consultant / General Practitioner (GP) / GP Registrar in charge of the patients care.

7.3 A DNACPR decision can be made by another Senior Doctor (ST3 or equivalent and above, Specialty or Associate Specialist [SAS] Doctors who have been delegated the responsibility by their employer) or Registered Nurse (Band 6 or above) who has achieved the required competency (appendix 4). These decisions must be verified by the Consultant / GP within 72 hours or prior to discharge (whichever is sooner) in order to remain a valid decision.

7.4 In certain circumstances where a patient clearly expresses a wish not to be resuscitated, a DNACPR form can be completed by a Junior Doctor. This decision must be discussed with a senior, and verified by a Consultant / GP as soon as possible and within the 72 hour timeframe or prior to discharge, whichever is sooner.

7.5 Patients who have made a decision that they would not want CPR should inform, where able, those looking after them that there is a valid documented Advanced Decision to Refuse Treatment (ADRT) referring to them and where it can be found. Please refer to the Advanced Decision to Refuse Treatment policy for details regarding the steps to be taken upon receipt and / or notification of the existence of an ADRT.

7.6 The Chief Executive of Isle of Wight NHS Trust is responsible for:

• ensuring that this policy adheres to statutory requirements and professional guidance
• ensure that the policy is agreed and monitored by the organizations governance process
• procuring and / or providing legal support.

7.7 Associate / Clinical Directors, Clinical Leads, Managers and Heads of Service 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
• DNACPR forms, leaflets and policy are available as required
• The policy is audited using the audit template (appendix 3), and results are disseminated through the appropriate governance processes / reporting lines.

7.8 Consultants / GPs / GP Registrars making DNACPR decisions must:

• be competent to make the decision
• must verify any DNACPR decision made by a delegated medical professional (outlined in 7.3 & 7.4 above) within 72 hours and / or before hospital discharge, whichever is the sooner
• ensure the decision is documented (see 8.8 & section 9)
• involve the individual, following best practice guidelines when making a decision (see 8.5, 8.6 & 8.7) and, if appropriate, involve relevant others in the discussion
• communicate the decision to other health and social care providers
• review the decision if necessary.

7.9 A Registered Nurse with the required competency making DNACPR decisions must:

• be competent to make the decision
• ensure the decision is documented (see 8.8)
• involve the individual, following best practice guidelines when making a decision (see 8.5, 8.6 & 8.7) and, if appropriate, involve relevant others in the discussion
• communicate the decision to other health and social care providers
• review the decision if necessary.

7.10 Health and social care staff delivering care must:

• adhere to the policy and procedure
• notify their manager of any training needs
• sensitively enquire as to the existence of a DNACPR or ADRT
• check the validity of any decision
• notify other services of the DNACPR decision or an ADRT on the transfer of a person, ensuring that the valid copy of the decision remains with the person
• participate in the audit process
• ambulance service staff (including private providers) must adhere to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), as well as relevant local Policies and Guidelines.

8 Policy detail/Course of Action

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 applicable ADRT is in place and made known
• a suitably empowered LPA is present at the point of the arrest, this individual will then make the decision regarding commencement of CPR
• there is clear evidence of a recent verbal refusal of CPR as this needs to be considered when making a best interests decision.

8.3 In the event of registered health care staff finding a person with no signs of life and clear clinical signs of prolonged death (i.e. rigor mortis, dependent lividity), and with no DNACPR decision or ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR. Provided the clinician has demonstrated a rational process in decision making, the Isle of Wight NHS Trust will support the member of staff if the decision is challenged. 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 or 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.

8.4 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 individuals 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 have a valid applicable ADRT.

8.5 The summary decision making framework is illustrated in appendix 1. When considering making a DNACPR decision for an individual it is important to consider:
  • is Cardiac Arrest (CA) a clear possibility for this individual? If not, it may not be necessary to go any further
  • if CA 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 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 mental capacity, an LPA will make the decision. If an LPA has not been appointed a best interests decision will be made
  • if the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death, where the patient has capacity this decision should be discussed with them, if a patient lacks mental capacity these discussions should take place with their LPA, IMCA or family member(s), this should be clearly documented in their notes.

8.6 Responsibility for decision making needs to take into account a number of factors:
  • A competent patient can:
    - Make an advance refusal of CPR
    - Accept (consent to) CPR if offered
  • A patient who has mental capacity has no legal right to demand CPR (or any other medical treatment) if the responsible senior clinician and multi-professional healthcare team judge that it would not be medically successful in achieving sustainable life
• Family / carers of a patient who has mental capacity should not be involved in resuscitation discussions without the patient's consent
• Where a patient lacks mental capacity for involvement in advanced decision and has no legally appointed LPA for health and welfare, or CAD the responsibility for deciding if resuscitation is in the patients' best interest's lies with the lead clinician with clinical responsibility for the patient. Family / carers do not have decision-making rights or responsibilities in this circumstance. Discussion with the family has the primary aim of trying to clarify the patients views, prior to incapacity, and forms part of the best interest decision process
• Where a patient lacks mental capacity for involvement in advance decisions and a legally appointed LPA for health and welfare of CAD has been identified the proxy decision maker can:
  - Make an advance refusal of CPR for the patient
  - Accept (consent to) CPR if offered (and judged by the responsible clinician and multi-disciplinary healthcare team to be likely to achieve sustainable life for the patient)
• The proxy decision maker cannot demand CPR (or any other medical treatment) if the responsible senior clinician and multi-professional healthcare team judge that it would not be medically successful in achieving sustainable life.

8.7 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:
• the patient should be given as much information as they wish about their situation, including information about CPR in the context of their own illness and sensitive communication around dying and end of life planning
• where a DNACPR decision is made on clear clinical grounds because CPR would not be successful, there should be a presumption in favour of informing the patient of the decision and explaining the reason for it. Those close to the patient should also be informed and offered explanation, unless a patient's wish for confidentiality prevents this. Emotional distress caused by this discussion is not a sufficient reason to avoid initiating the conversation.
• if a DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid such discussions this must be clearly documented along with the reasons
• if a DNACPR decision is made following discussion with the patient / others, this must be documented in their notes
• a DNACPR information leaflet should be made available where appropriate to individuals and their relatives / carers.

Documenting and communicating the decision

8.8 Once a decision has been made it must be documented on the Ceiling of Treatment and Resuscitation Decision Record (appendix 2) as well as being recorded in the notes. The original Ceiling of Treatment and Resuscitation Decision Record ("Purple Form") must stay with the patient at all times.
• The person's full name, Date of Birth, IW or NHS Number and Date of Decision must be clearly written on the form.
• If a decision has been made not to resuscitate the patient, the clinician's signature should be placed in the Do Not Attempt Resuscitation box. Specifics related to this decision should be recorded in section 5.
• If there has been a ceiling of treatment decision made, this should be clearly indicated on the form with a signature in the appropriate box, and any specifics related to the ceiling identified clearly documented on the form.
• If the patient is deemed not to have mental capacity, it should be clearly documented who the discussion was with. The full assessment should be clearly documented in the patient’s notes.

• In hospital, once completed, the first carbonated copy should be retained in the patients notes, the second carbonated copy should be sent to the Ambulance Hub where its existence will be logged onto the GP and Ambulance systems, as well as being scanned into the Trusts electronic records system against patients record as a ‘Clinical Alert’ on the Special Register.

• In hospital, the purple copy of the form should be filed at the front of the Patients notes and its existence communicated with the clinical team caring for the patient.

• In the community, the purple copy of the form should be left with the patient or carers. The first carbonated copy should be retained in the patients notes, the second carbonated copy should be sent to the Ambulance Hub where its existence will be logged onto the GP and Ambulance systems, as well as being scanned into the Trusts electronic records system against patients record as a ‘Clinical Alert’ on the Special Register. The Purple form should be taken to hospital for appointments as well as for planned or emergency admissions.

• On discharge from hospital, the patient or carers should be given the purple copy of the form and they should be encouraged to place the form into the ‘message in a bottle’ in the person’s refrigerator at home. If the ‘message in a bottle’ is not available, a system must be put in place to ensure effective communication of the DNACPR form’s location to all relevant parties including the ambulance service.

• Information regarding the background of the decision, those involved in the decision and a full explanation of the process, must be recorded in the individual’s notes. In instances where the individual has not been involved or informed of the decision, either through lack of capacity, or a refusal to discuss the decision, clear documentation as to the reasons why, and if necessary, documentation of the mental capacity assessment must be included in their notes.

8.9 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 staff may disclose confidential information to people close to them where this is necessary to discuss the individuals care and is not contrary to their interests.

Discharge from hospital/transfer process

8.10 Prior to discharge, the patient, or relevant other if the patient lacks mental capacity, MUST be informed of the decision. If the person is competent and refuses to discuss the decision, or if the discussion is likely to cause distress then this should be sensitively done. The same approach should be taken towards discussion with family members.

If such a decision is likely to cause undue distress then it is usually impossible to place a DNACPR form in the person’s home until further discussions have taken place.

8.11 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

• where appropriate, the person (or those close to the person if they lack mental 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 ambulance service have been informed via the warning flag procedure (see 8.8)

8.12 Hospital discharge summaries must include details of the DNACPR decision that has been put in place, and can be achieved by completing the free text part of the discharge summary on the Trust electronic patient records system.

8.13 Cross boundaries: If a patient is discharged from an institution other than one covered by the Isle of Wight NHS Trust, providing the DNACPR form used has been agreed using clear governance and legal process, it will be recognised by staff, until where necessary the decision is transferred onto the IOW NHS Trust Purple Form. The same process applies to older versions of the Purple Form upon its revision and publication of this policy.

9 Consultant / GP / GP Registrar Verification and Review

9.1 The Consultant / GP / GP Registrar responsible for the patient's care will review and verify the decision (if decision has been made by appropriate medical / nursing staff – see 7.3 & 7.4) at the earliest opportunity and countersign the form.

9.2 The decision will be regarded as ‘indefinite’ unless:
• a definite review date is specified
• there are relevant changes in the person's condition
• the patient expressed wish changes when the decision was based on these

9.3 The frequency of review should be determined by the Consultant / GP responsible for the patient's care, however, it is recommended that decisions in place should be reviewed in the context of substantial clinical condition change (in either direction) or prognosis, or transfer of the patient to a different location (including transfer within healthcare establishment).

9.4 Review should take place when / if specified, when patient circumstances change or patient wishes change as outlined in 9.2. If the ceiling of treatment or resuscitation status decisions change in light of the review, the current decision should be clearly struck through with two lines and the review section completed reflecting the changes to the new decision, signed and verified as appropriate (as outlined in 9.1). Where possible, a copy of the new decision should be made and sent to the Ambulance Hub to be recorded on the electronic systems as outlined in 8.8. If the decision has been reviewed and there is no change necessary, this review should be documented in the patient's clinical notes.

9.5 The last recorded decision on the original form is the current decision and should be treated as such. Electronic copies / photocopies of the original form should not be used to withhold treatment / CPR as they may be out of date.

9.6 It is important to note that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore when a Ceiling of Treatment / DNACPR decision is reviewed, the clinician 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 is 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 any treatment, even if that refusal results in death and any treatment carried out against their wishes is technically assault. In these circumstances individuals should be encouraged to make an ADRT.

10.2 Should the person refuse CPR, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual and possibly their relatives has taken place. A Ceiling or Treatment and Resuscitation Decision Record must also be completed.

10.3 A verbal request to decline CPR is not legally binding; however it should not be ignored and does need to be taken into account when making a best interest decision. The verbal request needs to be documented by the person who it is directed to and any decision to take actions contrary to it must be robust, accounted for and documented.

10.4 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a Ceiling of Treatment and Resuscitation Decision Record in their possession. An appropriate sensitive discussion with the person should aim to secure their understanding and acceptance of the DNACPR decision. Ongoing patient education, a period of time for reflection and opportunities for discussion will often result in agreement.

10.5 Although individuals do not have a legal right to demand that doctors carry out treatment against their clinical judgement, the person’s wishes to receive treatment should be considered wherever possible.

10.6 In the case of ongoing disagreement a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought. Whilst awaiting the outcome of such advice, in the event of cardiac or respiratory arrest CPR should be initiated.

11 Temporary suspension of a DNACPR decision

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

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

11.3 Pre-planned: Some procedures could precipitate a CA, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion, or surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether the DNACPR decision should be temporarily suspended during the procedure. Discussion with key people, including the person if appropriate, will need to take place.
12 Consultation

This policy has undergone a period of consultation within the Isle of Wight NHS Trust to include all associated and relevant parties.

13 Training

13.1 This DNACPR policy does not have a mandatory training requirement, but the following core components of this policy are included within mandatory adult resuscitation training:

- Responsibility for DNACPR decision making
- Decision making process
- Documentation of DNACPR decisions
- Verification of DNACPR decisions by Consultants
- Communication of DNACPR decisions
- Discharge/transfer of patients with DNACPR decisions

13.2 When approved this document will be available on the Intranet and will be subject to document control procedures.

13.3 Notification of new and revised documentation will be issued through e-bulletin and on staff notice boards where appropriate.

13.4 Staff using the Trust's intranet can access all procedural documents. It is the responsibility of managers to ensure that all staff are aware of where, and how, documents can be accessed within their areas of work.

13.5 It is the responsibility of each individual who prints a hard copy of any document to ensure that the printed hardcopy is the current version. Current versions are maintained on the intranet.

14 Monitoring Compliance and Effectiveness

14.1 Compliance against this policy will be audited monthly by Ward / Departmental Managers using the audit template found in appendix 3.

14.2 Completed Audits will be submitted to the Resuscitation Officers and relevant Business Unit Quality Manager

- The audit results submitted to the Resuscitation Officers will be collated and reported to the Trust Resuscitation Committee every quarter, before submission to the Patient Safety, Experience and Clinical Effectiveness Committee (SEE)
- The audit results submitted to the Business Unit Quality Manager will be presented as part of their quality report submissions.

14.3 The Resuscitation Service will perform a six monthly audit of all inpatient DNACPR decisions. This will be used as a control audit and results presented to the Trust Resuscitation Committee prior to submission to SEE.
14.4 Where issues are identified, actions taken to rectify those issues should be submitted with the audit and are the responsibility of the Ward / Departmental Manager.

14.5 Where persistent issues are identified by the Resuscitation Officers / Trust Resuscitation Committee an action plan to address the issues will be drawn up in conjunction with the Ward / Departmental Manager. Completion of / compliance with this action plan, will be monitored by the Trust Resuscitation Committee and reported to SEE.

14.6 Results of the audits will be used for future planning, identification of training needs and policy review.

15 Links to other Organisational Documents

- Adult Observation Chart Inc. Modified Early Warning Score (MEWS) policy
- Advanced Decision To Refuse Treatment policy
- Ambulance Service Conveyance Policy
- End of Life Care policy
- Resuscitation policy
- Mandatory Training Policy
- Reporting Adult Deaths to the Coroner, Completing Death Certificates and Cremation Forms.

16 References

British Medical Association, Resuscitation Council (UK), Royal College of Nursing (2016). Decisions relating to cardiopulmonary resuscitation, Guidance from the British Medical Association, the resuscitation Council (UK) and the Royal College of Nursing. Available at: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ accessed 11th April 2017.


### 17 Appendices

- **Appendix 1** Decision Making Framework
- **Appendix 2** Ceiling of Treatment and Resuscitation Decision Record
- **Appendix 3** Ceiling of Treatment and resuscitation Decision Record Audit Tool
- **Appendix 4** Competency Framework for DNACPR Decisions
- **Appendix 5** Financial and Resourcing Impact Assessment on Policy Implementation
- **Appendix 6** Equality Impact Assessment (EIA) Screening Tool
- **Appendix 7** Addendum to the Isle of Wight NHS Trust Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy
Appendix 1
Decision Making Framework

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

No

Yes

Is there a realistic chance that CPR could be successful?

No

Yes

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

Yes

No

If a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it (see section 5). Those close to the patient should also be informed and offered explanation, unless a patient’s wish for confidentiality prevents this.

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

Where a patient lacks capacity, the decision should be explained to those close to the patient without delay. If this is not done immediately, the reasons why it was not practicable or appropriate must be documented (see section 5).

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

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

If an attorney, deputy or guardian has been appointed they must be consulted (see sections 9.1 and 10).

Discussion with those close to the patient must be used to guide a decision in the patient’s best interests (see section 10). When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate, unless the child objects (see section 11).

Respect and document their refusal (see section 6.3). Discussion with those close to the patient may be used to guide a decision in the patient’s best interests, unless confidentiality restrictions prevent this.

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

British Medical Association, Resuscitation Council (UK), Royal College of Nursing (2016)
Appendix 2

Ceiling of Treatment and Resuscitation Decision Form

Section 1: Patient Details:
This section must be completed in full to include the patient’s name, Date of Birth and either IW or NHS number.

Section 2: Date of Decision:
The date of the decision must be recorded clearly in the box provided.

Section 3 (on the review page): Decisions relating to Cardiopulmonary Resuscitation:
If the patient is for Cardiopulmonary Resuscitation, sign the Attempt Resuscitation call 999/112 box. If the patient is not for Resuscitation sign the DO NOT Attempt Resuscitation box.
If the patient has a valid Advanced Decision to Refuse Treatment (ADRT), although not necessary, it is recommended that a Ceiling of Treatment and Resuscitation Decision Record is completed to aid rapid and easy identification of treatment and resuscitation decisions. If this decision changes the review section should be completed to reflect the changes made and the new decision.

Section 4 (on the review page): Decisions around Ceiling of Treatment:
Two broad decisions are outlined here: a signature should be placed in the appropriate box relating to the escalation/ceiling of treatment appropriate for the patient. Sign the Active Treatment box for those patients for whom active treatment such as resuscitation is to be attempted by the local medical and surgical intervention. If treatments or admission to hospital is provided. Sign the Optimal Supportive Care box for the patient for whom supportive treatment is appropriate, ensure that where appropriate these patients are considered for the principles of the Provider Care Bundle and/or the Priorities of Care package. If this decision changes the review section should be completed to reflect the changes made and the new decision.

Section 5 (on the review page): Reasons for, and discussions relating to decisions made:
Record in this space reasons for the decision that have been made in respect of ceiling of treatment/resuscitation. This space shall also be used for documentation of discussions held with the patient and/or family of the patient. If decisions have been taken off site, ensure that the decision is documented on the review page and in the patient’s notes.

Section 6 (on the review page): Assessment of Capacity:
If there is any doubt about a patient’s capacity to understand and communicate decisions around their future care and ceiling of treatment/resuscitation, they must undergo a formal assessment. This assessment must follow the guidelines set out in the Mental Capacity Act (MCA) and the Trust’s MCA Policy which is available on the Intranet. This assessment must be clearly documented and evidenced in the patient notes. If the person does not have capacity their relative or friends must be consulted and may be able to help by indicating what the person would do if able to do so. If there is one or more appropriate person to consult and the person has been assessed as lacking capacity, then an instruction to appoint an Independent Mental Capacity Advocate (IMCA) must 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 patient. If this power is included in the original LPA. You need to check this by writing the LPA. If the person has capacity ensure that any discussion(s) with others does not breach confidentiality. Indicate where the decision has been discussed with and document their name in section 5.

If the patient lacks mental capacity to make decisions about future care, consider if the care being suggested constitutes a deprivation of liberty and complete a DOLS referral as appropriate and in line with the Trust’s DOLS policy, found on the Intranet.

Section 7 (on the review page): Registered clinician making Ceiling of Treatment & Resuscitation Decision:
This section should be completed by the decision maker if they are not the Consultant/General Practitioner (GP) or GP Registrar in charge of their care. This form should be completed by Registrars at ST3 (or equivalent) and above, SAS Doctors, as well as appropriately trained and qualified Registered Nurses at Band 6 and above. This decision is valid for 72 hours, by which time the decision should be reviewed by the Consultant/GP responsible for their treatment/care and counter signed to remain a valid treatment decision.

Section 8 (on the review page): Consultant/GP decision/endorsement of Ceiling of Treatment & Resuscitation Decision:
This section is to be completed by the decision maker if the Consultant/GP responsible for the patient’s care, or the counter signatory of the Consultant/GP responsible for the patient’s treatment ratifying a decision made by the patient in Section 7 (or 14 in the review pages).

Review/update of treatment decision(s):
The initial decisions made and documented on the front page of this document can be changed/adjusted according to changes in patient condition, response to treatment and/or patient wishes. Changes of decisions made should be recorded in the Ceiling of Treatment & Resuscitation Decision Review section of this document. The case of the review decision must be clearly documented in Section 9 of the form. The previous decision should be clearly struck through with 2 diagonal lines, but not deleted.

The last completed section of this document is the current decision around Ceiling of Treatment & Resuscitation, and must be treated as such. Previous decisions should be struck through, but not deleted.
Ceiling of Treatment and Resuscitation Decision Record

1. Name:
   Date of Birth: ____________
   NHS or NW number: ____________
   DO NOT USE ADDRESSOGRAPH

2. Date of Decision
   __ __ / __ __ / ________

   ORIGINAL COPY WITH PATIENT

3. In the event of Cardiorespiratory Arrest:
   Attempt Resuscitation call 999/2222
   Signature: ____________
   OR
   DO NOT Attempt Resuscitation
   Signature: ____________

4. Ceiling of treatment:
   ACTIVE TREATMENT
   e.g. surgical and medical investigations and treatments*, referral to hospital*, on-call doctors or critical care outreach* and/or ICU* in the event of deterioration (*delete as applicable).
   Signature: ____________
   OR
   OPTIMAL SUPPORTIVE CARE
   e.g. analgesia and other comfort measures. This includes minimally invasive procedures to improve symptom control/quality of life (please document).
   Use the priorities of care documentation.
   Signature: ____________

5. Reasons for and discussions relating to decisions made (and/or reasons for not having discussions, if none has taken place) Please provide guidance on specific level of intervention(s) below:

   Preferred place of treatment/care:
   - Hospital
   - Hospice
   - Cara Home
   - Own Home

6. Assessment of Mental Capacity (must be completed by clinician who signs this form):
   - Patient has capacity to make and communicate decisions about their future treatment
   - Patient’s capacity is in question for one or more parts of the discussion (please document above):
   Decision discussed with: □ Patient □ Relative □ Nominated representative □ Independent Mental Capacity Advocate
   All decisions must be made in the patients best interest and comply with current legislation (MCA)

7. Registered clinician making Ceiling of Treatment & Resuscitation Decision (to be countersigned within 72hrs)
   Signature: ____________
   Name: ____________
   GMC/NMC number: ____________
   Date: ____________
   Time: ____________

8. Consultant/GP decision/endorsement of Ceiling of Treatment & Resuscitation Decision
   Signature: ____________
   Name: ____________
   GMC/NMC number: ____________
   Date: ____________
   Time: ____________

The last completed section of this document is the current decision around Ceiling of Treatment & Resuscitation, and must be treated as such.
Ceiling of Treatment and Resuscitation Decision Record

9. Date of Review
   ___ / ___

10. In the event of Cardiopulmonary Arrest:
   Attempt Resuscitation call 999/2222
   OR
   DO NOT Attempt Resuscitation
   Signature:

11. Ceiling of treatment:
   ACTIVE TREATMENT
   e.g. surgical and medical investigations and treatments, referral to hospital, on-call doctors or critical care outreach and/or ICU in the event of deterioration (*delete as applicable).
   Signature:

   OPTIMAL SUPPORTIVE CARE
   e.g. analgesia and other comfort measures. This includes minimally invasive procedures to improve symptom control and quality of life (please document).
   Use the priorities of care documentation.
   Signature:

12. Reasons for, and discussions relating to review decision (including specifics relating to Ceilings of Treatment):

Preferred place of treatment/care:
☐ Hospital  ☐ Hospice  ☐ Care Home  ☐ Own Home

13. Assessment of Capacity: Is previous capacity decision still valid? ☐ Yes ☐ No
   If No, please document reason and actions (Decision must be made by clinician signing this form).

14. Registered clinician making Ceiling of Treatment & Resuscitation Decision (to be countersigned within 72hrs)
   Signature: Name: Grade: GM/C/NMC number: Date: Time:

15. Consultant/GP decision/endorsement of Ceiling of Treatment & Resuscitation Decision
   Signature: Name: Grade: GM/C/NMC number: Date: Time:

Emergency Contacts:
<table>
<thead>
<tr>
<th>Welfare Attorney etc.</th>
<th>Name</th>
<th>Telephone numbers</th>
<th>Other relevant details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/friend</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Following completion:
- The purple copy of this form is to be given to the patient following completion in the community or discharge from hospital.
- The purple copy of the form holds the valid decision and must be seen by clinicians to guide treatment.
- The top carbon copy should be retained in the patient notes as a record of the decision made.
- The bottom carbon copy should be sent to the Ambulance Hub where a copy of the decision will be added to the Ambulance Dispatch System and Hospital Patient Electronic Record.
## Ceiling of Treatment and Resuscitation Decision Form Audit Tool

### Ceiling of Treatment and Resuscitation Decision Record (CTRDR) Audit Tool

**Isle of Wight**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of Beds occupied</th>
<th>Number of CTRDR forms</th>
<th>% of patients with CTRDR</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Beds occupied</th>
<th>Number of CTRDR forms</th>
<th>% of patients with CTRDR</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Total</th>
<th>%</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>IW:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Are there clear patient details? | 100% |
### Is the date of the decision documented? | 100% |
### Does the patient have mental capacity? | |
### Has the decision been discussed with the person? | 100% |
### If not discussed with the person, has the decision been discussed with relevant others? | 100% |

### Ceiling of Treatment:

- Active Treatment
- Optimal Supportive Care

### Resuscitation Status:

- Attempt Resuscitation
- Do Not Attempt Resuscitation

### Who has made the decision:

- GP
- Consultant
- SpR/SAS
- Nurse
- Other

### Is the record clearly dated, signed and signed correctly? | 100% |
### Has the decision been verified within 72 hours, if appropriate? | 100% |
### Has the review section been completed? | |
### Is the form valid? | 100% |

### Actions taken as a result of the Audit:

---

---
Appendix 4

Competency Framework for DNACPR Decisions

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decision Making Competency Framework

Communication Skills

1. Demonstrates respect, compassion, sensitivity and non-judgemental attitude
2. Demonstrates a willingness to ask difficult questions and sensitively communicates poor prognosis or contentious information or decisions
3. Supports patients and families through uncertainty, using knowledge of the impact of disease and its treatments to discuss care options and coping strategies
4. Recognises the opportunity, by picking up on cues, to hold deeper discussions relating to psychological, emotional or spiritual issues demonstrating higher level communication skills
5. Creates an empowering and affirming environment which help patients to make a difficult decision
6. Analyses complex patient situations and shares experiences and insights with others
7. Guides and supports others to improve communication skills amongst the team
8. Builds the credibility of the team through open and honest communication
9. Able to effectively liaise and work in collaboration with multi professional staff working across the range of health and social care settings
10. Can evidence advanced communication skills training

Knowledge & Skills

1. The healthcare professional is educated to at least degree level
2. Can provide evidence of continued professional development
3. Able within scope of practice to;
   a. Recognise patterns of disease progression and likely outcomes
   b. Use prognostic indicator guides to initiate timely end of life discussions and decision making
4. Shows respect for the ethical principles and application to practice in high level decision making
5. Aware of, and can demonstrate understanding of the following laws, policies and best practice and their application to practice;
   a. Current law and local policies in relation to DNACPR decisions
   b. Relevant Code of Professional Practice
   c. Mental Capacity Act (2005)
   d. DOLS
   e. Human Rights Act 1998
   f. End of life strategy
   g. Advanced decisions and care planning

**High Level Decision Making**

1. Has the ability to critically assess, analyse and interpret complex, clinical situations, communication and best interest decisions
2. Able to identify priorities quickly, maintaining a focus when multiple stimuli are presented
3. Anticipates and recognises the changing clinical status of a deteriorating patient and is able to weigh the burdens/benefits of investigations and treatments including CPR
4. Has current experience of working in the contextual environment in which end of life decisions are considered as part of daily practice e.g. working with patients with end of life issues, palliative care or long term conditions
5. Works with individuals in shared decision making around treatment options, within the principles of valid consent and best interests e.g. appropriateness of CPR or withdrawing or with holding life sustaining treatments / interventions
6. Applies professional judgement to making decisions and achieving appropriate care outcomes
7. Records in an accurate, detailed and contemporaneous manner the rationale for complex and best interest decisions
8. Facilitates discussion on research and evidence based practice
9. Demonstrates awareness of own limitations, prejudices and accountability and uses well developed reflective skills

**Organisational Skills**

1. Able to work within a team and also independently e.g. working with patients across transitional spaces such as liaison with hospital and community teams working collaboratively with all staff involved
2. Be able to demonstrate the ability to complete accurate, detailed and contemporaneous records as per the General Medical Council / Nursing and Midwifery Council standards
3. Can plan and organise complex activities and has shown diligence in completing projects, tasks and procedures
4. Demonstrate confidence and competence with IT systems relevant to role
5. Identifies and manages poor practice including recognition and reporting of clinical risk
6. Uses leadership, supervisory and facilitation skills to:
   a. Ensure awareness of changes in treatment plans, ethos of care
   b. Document and communicate changes across all relevant health and social care domains
7. Supports junior staff to develop skills in organising, prioritising and delegating
8. Understands and adheres to the need for working within boundaries, processes and systems
9. Demonstrate being innovative and self-directed
Appendix 5

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

<table>
<thead>
<tr>
<th>Document title</th>
<th>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totals</strong></td>
<td>WTE</td>
</tr>
<tr>
<td>Manpower Costs</td>
<td>0</td>
</tr>
<tr>
<td>Training Staff</td>
<td>0</td>
</tr>
<tr>
<td>Equipment &amp; Provision of resources</td>
<td>0</td>
</tr>
</tbody>
</table>

Summary of Impact: Nil

Risk Management Issues: Nil

Benefits / Savings to the organisation: Nil

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

<table>
<thead>
<tr>
<th>Manpower</th>
<th>WTE</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational running costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Totals:
<table>
<thead>
<tr>
<th>Staff Training Impact</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment and Provision of Resources</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation / facilities needed</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Building alterations (extensions/new)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IT Hardware / software / licences</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stationery / publicity</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Travel costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Utilities e.g. telephones</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Process change</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rolling replacement of equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Marketing – booklets/posters/handouts, etc.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals:</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- Capital implications £5,000 with life expectancy of more than one year.

| Funding /costs checked & agreed by finance:                                                      | n/a         |
| Signature & date of financial accountant:                                                       | n/a         |
| Funding / costs have been agreed and are in place:                                               | n/a         |
| Signature of appropriate Executive or Associate Director:                                       | n/a         |
## Equality Impact Assessment (EIA) Screening Tool

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of document</td>
<td>To outline the Trust's DNACPR process, staff responsibilities and associated paperwork</td>
</tr>
<tr>
<td>Target Audience</td>
<td>All Trust Staff</td>
</tr>
<tr>
<td>Person or Committee undertaken the Equality Impact Assessment</td>
<td>Senior Resuscitation Officer</td>
</tr>
</tbody>
</table>

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

   If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

   If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British People</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Black or Black British People</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Chinese people</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>People of Mixed Race</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>White people (including Irish people)</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>People with Physical Disabilities, Learning Disabilities or Mental Health Issues</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Transgender</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Lesbian, Gay men and bisexual</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>Children</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Older People (60+)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Younger People (17 to 25 yrs)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Faith Group</td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Equal Opportunities and/or improved relations</td>
<td></td>
<td>No</td>
<td>no</td>
</tr>
</tbody>
</table>

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal (it is not discriminatory under anti-discriminatory law)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intended</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:

3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

<table>
<thead>
<tr>
<th>Scheduled for Full Impact Assessment</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of persons/group completing the full assessment.</td>
<td></td>
</tr>
<tr>
<td>Date Initial Screening completed</td>
<td></td>
</tr>
</tbody>
</table>
Addendum to the Isle of Wight NHS Trust Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy

1. Executive Summary

1.1. This Addendum to the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy seeks to enable a named group of Registered Nurses to be able to sign Ceiling of Treatment and Resuscitation Decision Record (CoTRDR) forms as the Responsible Clinician, negating the need for a second signature from either a Consultant or GP, which at present is the current policy.

1.2. This addendum will cease to be in effect once the current (2017) DNACPR Policy is reviewed and updated later in 2019.

2. Introduction

2.1. The current Isle of Wight NHS Trust DNACPR Policy allows Registered Nurses at Band 6 or above who have achieved the required competencies (appendix 4 of the DNACPR Policy), to sign CoTRDR forms for patients for whom they have clinical responsibility. This decision is valid for a period of 72 hours, within which the General Practitioner (GP) or Consultant responsible for the patients care must review and countersign the form to verify the decision in order for it to remain a long-term valid decision.

2.2. At this present time, this generally involves the Nurse who is writing out the CoTRDR form, commonly in the patient’s home, having to take the form immediately after writing it to the GP Surgery for it to be countersigned, before returning it to the patient’s home address. The Community Palliative Care Team have to track down the Palliative Care Consultant and arrange to meet with them to get their forms countersigned, which, depending on workload can be challenging and involve in both circumstances significant travelling time, distances and disruption to the GP/Consultants workload.

2.3. The effort and time taken to get a countersignature on the CoTRDR form, often by a GP or Consultant who has not seen the patient, could be seen as a waste of a senior clinicians time, which could be better spent on delivering treatment/care. Concern has also been voiced by some Consultants that they are countersigning forms for patients whom they have not seen nor
assessed, yet are taking clinical responsibility for the decision that has been made.

3. Definitions

**Cardiopulmonary Resuscitation (CPR)** An emergency procedure involving interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs according to the latest guidelines from the Resuscitation Council (UK).

**Cardiac Arrest (CA)** 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.

**Ceiling of Treatment** Defines a ceiling of active treatment such that, if there is a failure to respond to that treatment; the patient may require appropriate end of life care.

**Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** Refers to not making efforts to restart breathing and/or the heart in the cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotics etc.

4. Scope

4.1. This addendum applies to staff employed by Isle of Wight NHS Trust and Mountbatten in the following roles:

- Clinical Director for End of Life Care, Consultant Nurse Critical Care, Clinical Lead Critical Care Outreach Service
- Sister Critical Care Outreach Service
- Critical Care Outreach Advanced Clinical Practitioner
- Integrated Palliative Care Team Nurse Specialist
- Integrated Palliative Care Team Discharge Coordinator
- Integrated Palliative Care Team Associate Nurse Specialist
- Consultant Nurse
- Mountbatten IPU Ward Manager
- CNS (Palliative Care) Team Leader
- CNS Palliative Care
- Clinical Nurse Manager, Palliative Care
- Lead Community Heart Failure Nurse Specialist
- Community Heart Failure Nurse Specialist
- Cardiac Rehabilitation Nurse
5. Purpose

5.1. The purpose of this addendum is to enable the Registered Nurses named in the Scope of this document to be the responsible clinician when signing Ceiling of Treatment and Resuscitation Decision Record Forms, negating the need for them to seek final sign off by a Consultant or GP.

5.2. This recognises the decisions they make as valid, long term decisions, discussed with and agreed by (where possible) the patient affected, in accordance with their level of advanced practice and level of autonomy in prescribing patient care/treatment options.

5.3. This addendum will provide clear guidance for staff, and cease to be in effect once the current (2017) DNACPR Policy is reviewed and updated.

5.4. This addendum will ensure that only those listed in the Scope of this document will be granted the licence to be single signatories on the CoTRDR forms, and that the Isle of Wight NHS Trust and Mountbatten Staff are clear that forms from these staff are valid, long term decisions.

6. Legislation and Guidance

6.1. Under the Mental Capacity Act (2005), staff are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

6.2. The following sections of the Human Rights Act (1998) are relevant to this policy:
   - The individual’s right to life (article 2)
   - To be free from inhumane 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 relation to these rights (article 14)

7. Roles and responsibilities

7.1. The information contained within this addendum is relevant to all health and social care staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. 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. Overall responsibility for making DNACPR decisions rests with the clinician in charge of the patients care.

7.3. The chief executive of the isle of Wight NHS Trust is responsible for:
   - 7.3.1. Ensuring that this addendum adheres to statutory requirements and professional guidance
7.3.2. Ensure that the addendum is agreed and monitored by the organisations governance process
7.3.3. Procuring and/or providing legal support

7.4. Associate Directors, Clinical Leads, Managers and heads of Service responsible for the delivery of care must ensure that:
7.4.1. Staff are aware of the addendum and know how to access it
7.4.2. The addendum is implemented
7.4.3. Staff understand the importance of issues regarding DNACPR
7.4.4. Staff are trained and updated in managing DNACPR decisions
7.4.5. DNACPR forms, leaflets and Policy are available as required
7.4.6. This addendum is reflected in the monthly auditing of the CoTRDR as outlined in the DNACPR Policy 2017.

7.5. Registered Nurses listed in the Scope of this document, with the required competency making DNACPR decisions must:
7.5.1. Be competent to make the decision
7.5.2. Ensures the decision is documented (see 8.8 of the DNACPR Policy 2017)
7.5.3. Involve the individual, following best practice guidelines when making a decision (see 8.5, 8.6 & 8.7 of the DNACPR Policy 2017) and, if appropriate, involve relevant others in the discussion
7.5.4. Communicate the decision to other health and social care providers
7.5.5. Review the decision if necessary

7.6. Health and Social care staff delivering care must:
7.6.1. Adhere to the current DNACPR policy and procedure (2017)
7.6.2. Notify their manager of any training needs
7.6.3. Sensitively enquire as to the existence of a DNACPR decision or ADRT
7.6.4. Check the validity of any decision, recognising those listed in the scope of this document as being able to sign off the CoTRDR as the ‘Responsible Clinician’
7.6.5. Notify other services of the DNACPR decision or an ADRT on the transfer of a person, ensuring that the valid copy of the decision remains with the person
7.6.6. Participate in the audit process
7.6.7. Ambulance service staff (including private providers) must adhere to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), as well as relevant policies and guidelines

8. Policy Detail/Course of Action

8.1. Section 8 of the DNACPR Policy 2017 must be adhered to with the exception of the need for a Consultant or GP needing to countersign forms completed by the Registered Nurses listed in the Scope of this document.
9. Consultation
9.1. This addendum has undergone a period of consultation within the Isle of Wight NHS Trust, and is a temporary measure until the updating and publication of the current DNACPR Policy is completed.

10. Training
10.1. Those staff listed in the scope of this document will have successfully completed the competency pack, addressing any educational needs identified during its completion prior to applying for this role as extended practice.
10.2. When approved this document will be available on the intranet and will be subject to document control procedures.
10.3. Notification of new and revised documentation will be issued through e-bulletin and on staff notice boards where appropriate.
10.4. Staff using the Trusts intranet can access all procedural documents. It is the responsibility of managers to ensure that all staff are aware of where, and how, documents can be accessed in their area of work.
10.5. It is the responsibility of each individual who prints a hard copy of any document to ensure that the printed hard copy is the current version. Current versions are maintained on the intranet.

11. References
British Medical Association, Resuscitation Council (UK), Royal College of Nursing (2016). Decisions relating to cardiopulmonary resuscitation, Guidance from the British Medical Association, the resuscitation Council (UK) and the Royal College of Nursing. Available at: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ accessed 11th April 2017.


