



## **“Sharing and Involving”**

# **A Clinical Policy For Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults In Wales**

Revised Policy: Version 3 July 2017

NHS Wales  
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

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DNACPR Form (Adult) DO NOT ATTEMPT CARDIO- PULMONARY RESUSCITATION (DNACPR) DECISION is included at the end of this document.

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## 1. Introduction and Objectives

Health professionals have a strong duty to make sure people who should have CPR receive it and those that should not, do not.

Cardio-respiratory resuscitation (CPR) can, in theory, be attempted on any person following a cardiac arrest. However, the clinical outcome is largely dependent on the individual clinical factors that led to the arrest. In many instances the procedure does not result in a good clinical outcome. There is significant risk of harm and prolonged suffering from CPR - including long term neurological effects and the need, in some cases, for prolonged admission to ITU and a possible further cardiac arrest resulting from the underlying disease process.

Inappropriate attempts at CPR can lead to unnecessary distress for patients, their family and trusted friends, may involve the Ambulance Service and even the Police which can clearly cause further distress.

The clinical intervention of CPR as a result may not be appropriate for all patients. It therefore follows that a decision not to attempt CPR should be reached on the basis of a proper, appropriately informed discussion with patients involving those who are particularly important to them.

There has been increased focus on matters relating to Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR). This is possibly a reflection of the fact that the clinical and ethical issues are acknowledged to be of such an important and personal nature. Whilst we meticulously plan care with patients for interventions at the beginning of life, all too often we fail to have equally important discussions relating to a patient's wishes at the end of life. Frequently it seems that there is too little discussion too late.

A quick-reference document, which should be read in conjunction with this policy, is provided comprising a summary of the key elements of this policy, along with an information leaflet for patients, relatives and others closest to them.

### 1.1 Purpose and Scope of this Policy

This policy applies to all NHS Wales staff and the care of patients of 18 years of age and over in all care settings within the remit of NHS Wales. It specifically relates to cardio-pulmonary resuscitation (traditionally referred to as "CPR"), synonymous with cardio-respiratory resuscitation, which is the attempted restoration of circulation and breathing in someone in whom both have stopped. It does not apply to other treatments and care, including procedures that are sometimes loosely referred to as 'resuscitation' such as rehydration, blood transfusion, intra-venous antibiotics etc.

#### **Workshop Comment:**

***"It should become more of a routine to ask of a patient's wishes about resuscitation"***

***"This policy hopes to start a more open dialogue in relation to patients' wishes at the very end of life".***

NHS Wales is responding to the need to introduce substantial improvements with regard to DNACPR decisions involving adults in order to achieve more appropriate patient-centred care. The focus is on respect for the wishes of individuals in order to facilitate the provision of appropriate care at the very end of life and the need for discussions to take place in a shared and planned way, at an earlier stage, across all settings including the home and community.

The purpose of this policy is to provide a framework for professionals and NHS bodies in Wales to facilitate a consistent approach to decisions about the provision of CPR. This policy is compatible with Welsh policies on organ donation and consent. While death is inevitable, achieving a dignified, sensitive and shared approach to reaching a decision relating to CPR is vital for patients, their families and their close friends. DNACPR decisions should always involve senior professionals. DNACPR discussions can be challenging and they should be conducted in a calm, professional and reflective manner.

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The decision not to attempt CPR on a patient is a **major clinical decision**. The clinical course leading up to this point may be of short duration for some patients. For others it may follow a more gradual decline in health.

The decision as to whether a patient would want physical attempts (CPR) to maintain their circulation and breathing in the event of a cardiac arrest is also a **serious personal decision**. In most cases a DNACPR decision will be made after a careful, planned discussion in partnership with the patient and involve those closest to them. Decisions relating to DNACPR must be accorded a high level of prominence to ensure that discussions are allocated sufficient time.

It is possible to identify those patients in whom cardio-respiratory arrest represents the natural end to their illness. A **“clinical concept” of a Natural Anticipated and Accepted Death (NAAD)** is introduced in this policy in order to offer guidance to clinicians as to when to consider a discussion in those cases where CPR would represent an unsatisfactory, undignified and clinically inappropriate intervention – or possibly where the burden of CPR in clinical context clearly outweighs realistic benefit. An individual patient-centred approach is vital. The patient’s fully informed personal perspective on CPR is of great importance, viewed in the wider clinical context. It is also very important to identify those patients who adamantly refuse CPR, following informed discussion.

**Workshop comments:**

*“All too often - DNACPR discussion seems to be “too little - too late”.*

*“The complications of CPR and also the concept of natural anticipated accepted death should be more openly discussed”*

This policy has been developed in partnership with key clinical and non-clinical stakeholders in order to develop a consistent approach to DNACPR across the NHS in Wales and to ensure that the decisions reached are based on an individual patient's needs. It outlines an open, personal approach to DNACPR decision-making in Wales, an approach understood by clinicians, patients and their families - acknowledging the particular circumstances of every patient.

**Objectives of this policy**

The overriding principles of this policy are:

1. To ensure an individual’s life is respected and valued.
2. To ensure early senior clinical involvement and accountability in the decision making process.
3. To make clear that a DNACPR decision must not prejudice any other aspect of care.

The primary objectives of this DNACPR policy are:

- To ensure that this important discussion is accorded the highest level of significance.
- To develop across NHS Wales the approach of consistent planning with regard to CPR as an intervention being based on an individual plan for every patient.
- To ensure an integrated approach to making DNACPR decisions.
- To ensure that an individual patient plan is in place across all relevant care settings.
- To ensure correct and effective communication to all those involved in the patient’s care.
- To ensure that decisions regarding CPR are made taking into account:
  - Whether CPR is likely to succeed
  - The clinical needs of the patient
  - The patient’s wishes
  - Sound ethical principles
  - All relevant legislation (for example the Human Rights Act (1988) and the Mental Capacity Act (MCA) 2005 and the duties and obligations set by professional regulators.

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- To make DNACPR decisions in a transparent way that is open to examination.
- To avoid inappropriate CPR attempts in all care settings.
- To ensure staff, patients, their trusted friends and family have appropriate information on making advance decisions relating to CPR and that they are able to discuss resuscitation issues when they wish to do so and that they understand the process.
- To clarify that patients will not be asked to decide on CPR when it would be highly likely to fail - although they should be informed.
- To ensure that clinical staff who are caring for people with communication difficulties or who may be vulnerable will provide a decision making process that is clear and appropriate for their needs.

**Audit Point 1 – The ‘nature’ of a DNACPR decision and the importance of good communication**

**Clinical staff must understand the personal implications of a DNACPR decision. Achieving this requires clinical reflection, excellent communication and informed decision making. If personal discussion with the patient is not possible (including for reasons of mental capacity) the same principles must apply.**

**2. Definitions**

Throughout this policy “DNACPR” refers solely to the provision of Cardio-pulmonary resuscitation and not to any other aspect of the individual’s care or treatment options.

**2.1 Cardiac Arrest**

This is the sudden cessation of a clinically detectable cardiac output.

**2.2 Cardio-Pulmonary Resuscitation (CPR)**

CPR is an intervention delivered with the specific intention of restoring and maintaining circulation and breathing. CPR is a physical and relatively invasive process. It usually comprises chest compressions with the mechanical ventilation of the lungs, possibly defibrillation by electric shocks and the injection of medication. It is increasingly referred to in the literature as cardio-respiratory resuscitation.

**2.3 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)**

This refers to a specific advance decision NOT to initiate CPR in the event of a cardiac arrest. It must be made clear to the patient, those close to the patient and also to the health care team that a DNACPR decision does not have repercussions on any other element of care.

**2.4 Joint Statement (see section 11)**

The joint statement refers to the BMA, Resuscitation Council (UK), and RCN’s report - “Decisions Relating to Cardio-pulmonary resuscitation” (2014). This update of earlier guidance represents a very important UK document in this clinical arena.

**2.5 Mental Capacity**

The Mental Capacity Act 2005 Section 1(2) recognises the basic principle that an adult must be presumed to have the capacity to make their own decisions unless it can be established that they are not able to understand, use or weigh up the information needed to make the DNACPR decision and/or communicate their wishes. A person must be assumed to possess the mental capacity to make a particular decision unless the reverse can be positively demonstrated for that *specific* decision. Identifying early on in the course of an illness the possibility that the patient may, at some time in the future, lose the capacity to decide for themselves will ensure that, wherever possible, a well-informed DNACPR decision can be reached or, where appropriate, achieved in the patient’s best interests.

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## 2.6 Independent Mental Capacity Advocate (IMCA)

If the patient who lacks the mental capacity to take the specific decision does not have family or friends who are willing, and able, to be consulted an IMCA should be instructed. Please refer to your MCA lead when required.

## 2.7 Advance Decision to Refuse Treatment. (ADRT)

This refers to a decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding. Note that neither the patient, nor anyone on their behalf can insist on treatment that the clinical staff do not feel is in their best interests *even* if such insistence is included in a written document. Refer to the Mental Capacity Act and the Code for further details and in the event of uncertainty with regard to the validity of the document seek legal advice.

## 2.8 Lasting Power of Attorney for Health and Welfare or Court Appointed Deputy

Both of the above may have legal powers to assist with the decision making process where the patient lacks capacity. However, care should be taken to check the validity of any held documentation and the scope of their powers. Where such persons are considered not to be acting in the patient's best interests it is important to seek legal advice.

# 3. Policy development and implementation

## 3.1 Process of policy development

This policy was developed following a series of meetings to evaluate current local policy positions across Wales, and through meetings with health professionals, patient groups and key national stakeholders. The process of development included clinical workshops in North Wales, West Wales and South-East Wales testing and adjusting the discussion framework and the All Wales DNACPR form. Members from a wide range of clinical communities were represented and a broad range of non-clinical stakeholders were engaged through stakeholder events. A consistent theme received at events was that a policy **must reflect a culture of “openness and candour” when a clinician broaches the subject of DNACPR** – a culture which also affords the opportunity for patients and those closest to them to raise the subject of DNACPR themselves.

The approach to developing this policy has been grounded in the public sector equality duty principles of evidence, transparency; engagement and leadership in order to ensure that it impacts in a fair and positive way. Engagement with a range of third sector organisations has raised awareness of issues relating to DNACPR and this policy is a product of this wide engagement.

## 3.2 Principles of policy implementation

Health professionals across NHS Wales must be made aware of this policy and also of their responsibilities to patients and those closest to them in order to meet the standards required. Staff should be made aware of this clinical policy through training measures (see Section 10) employing Local Health Board mechanisms in accordance with the local management of policies and procedures. This requires Health Boards to work closely in partnership with the other key organisations including the Welsh Ambulance Service. Staff must operate this policy within NHS systems of information governance, with the clinical information relating to DNACPR being accessible to those teams providing clinical care for the patient. It is recognised that there may be exceptional clinical circumstances when a first responder has to make an immediate decision that favours the right to life with no time to evaluate DNACPR status, hence providing CPR as the clinical situation demands.

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## 4. DNACPR in practice – key principles

### 4.1 When DNACPR status is unknown

Unless a valid DNACPR decision is in operation with either a completed All Wales DNACPR form or a valid Advance Decision to Refuse Treatment (ADRT) specifically relevant to the CPR decision exists all patients must be presumed to be “for CPR”. If a significant possibility of a cardiac arrest or death cannot be envisaged, then there is no medical decision to make.

### 4.2 Circumstances when CPR would not restore circulation and breathing

If the senior clinician in charge of the patient, in liaison with the clinical team, are as certain as they can be that CPR will not re-establish effective circulation and breathing in the patient then CPR should not be offered or attempted. When this is the case, discussion with the patient should take place in the spirit of good practice and openness. For some patients there may be individual clinical circumstances where such discussion might lead to harm and not provide relief; in such circumstances the clinical reasons for avoiding discussion with the patient must be clearly documented.

### 4.3 DNACPR Discussion – openness, with confidentiality and in partnership

All patients faced with this discussion require support from those providing care. Whenever possible, with patient consent, the person(s) they have chosen to be involved in discussions about their care and treatment should be invited to be present during the discussion. The clinician must be aware of the current clinical status and the benefits and risk of harm from CPR. A discussion can ensue and a shared decision can then be reached in partnership. Patient confidentiality must be respected at all times.

**Workshop comment:**

***“Discussing DNACPR in the community setting means that a clear plan is understood by all”***

All competent patients have the right to refuse to participate in DNACPR discussions. They can also refuse permission to share the outcome of the discussion with any third party. Such decisions must always be respected and documented in the patient’s records. A clinician should not force information on a patient which is likely to cause harm. A risk of harm in this context, or an indication from the patient that they do not wish to be informed about CPR, must be justified in the clinical record.

### 4.4 DNACPR Discussion – communication with those close to the patient

Whenever clinically possible, all patients should be offered the opportunity of support from a close individual for the DNACPR discussion. A decision to refuse such an offer of support must be respected and recorded. Individuals close to the patient will naturally be anxious about them and whenever possible should be kept informed of the clinical progress of the patient. Whilst such discussion between the patient and those closest to them are to be encouraged, if a private DNACPR discussion is requested by the patient, it is sensible at its conclusion to confirm with the patient whether they wish the conversation to remain in confidence. You must respect the position and record that decision in the clinical record.

***“Staff should bear in mind that those most close to the patient may not always be immediate family members”***  
***(Transgender Wales)***

Before making and recording a DNACPR decision for a patient who lacks capacity to decide about CPR, those close to the patient, who can help inform a best interests decision should be consulted, so long as it is practicable to do so, unless the clinician can see any reason why this would not be right. If the decision is urgent it is usually possible to consult them even if it is inconvenient. If a DNACPR decision is not urgent, consider deferring it until relevant people close to the patient are available. If the decision is to be ‘made on a balance of benefits and risks’, those close to the patient may have

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information about 'previously expressed wishes and about what (outcomes) the patient would have been likely to consider acceptable'. Such information will inform a decision one way or the other. If the decision is to be made because 'CPR would not be successful', discussion with those close to the patient will involve information and explanation about CPR and about a DNACPR decision [refer to the 3<sup>rd</sup> edition (1<sup>st</sup> revision) Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing June 2016].

Further information and guidance is available at:

<http://talkcpr.wales/>

And in the patient information leaflet at:

<http://www.wales.nhs.uk/researchandresources/publications/informationforpatientsandcarers>

#### 4.5 Documentation of the DNACPR discussion:

The standard All-Wales documentation for adult DNACPR decisions must be used in the NHS Wales in order to reduce risk and to aid clear communication about the decision.

#### 4.6 Wider communication of DNACPR decisions:

Immediate and effective communication of a DNACPR decision must take place so that all those involved with current and future care are made aware. It is the responsibility of the senior responsible clinician when countersigning the DNACPR form, to ensure appropriate communication. The original document must be prominently placed in the patient's current medical record. For all settings this may include raising awareness outside the immediate place of care (see section 6.4).

## 5. Making a DNACPR Decision

### 5.1 When should a DNACPR discussion be contemplated?

Recognising the right time to consider DNACPR may not be easy but an anticipated cardiac arrest or death in light of the current illness forms its basis. Understanding wishes expressed by the patient represents a fundamental element of good care and making DNACPR decisions **before** a patient becomes too unwell or loses the capacity to make the decision should be the aim. This requires the establishment of a bond of trust with the patient, family and others close to them.

The discussion should usually be conducted by an experienced team-member. If no DNACPR decision is in place and no specific Advance Decision on CPR exists (i.e. the wishes of the patient are not known) the presumption is that CPR will be provided. This applies unless at the time of an arrest the clinician is certain that they possess sufficient information about the patient to judge that CPR cannot be successful.

#### Audit point 2 – Clinical teams require time to discuss DNACPR issues

**An anticipated cardiac arrest or death should instigate team discussions to identify those patients with whom a DNACPR discussion is warranted. This should become part of clinical routine – so that DNACPR is usually discussed before the need for an urgent response.**

#### **Workshop comment:**

***“The “appropriateness” of a “CPR call” is not usually one for the resuscitation team”.***

Clinical presentations can be highly variable. In some cases the level of physiological compromise at presentation indicates a likely imminent decline to a cardio-respiratory arrest. For others a more gradual deterioration may be the anticipated course. Sometimes a decline in health may be first suspected by carers and those closest to the patient

and occasionally by the patient themselves. These represent common general clinical scenarios when a DNACPR position might initially be considered.

### Audit point 3 - Team discussion relating to DNACPR

The possibility of a cardiac arrest should lead to a team discussion relating to DNACPR - with an additional community perspective whenever possible. The clinical decision framework (section 5.2) may be a helpful guide. The decision to move to a DNACPR discussion should be recorded. The DNACPR discussion itself should take place as soon as possible thereafter (within 12 hours).

#### 5.1.1 If CPR will not restart the patient's heart and maintain breathing

If the clinical team is **as clinically certain as possible** that attempting CPR would not re-establish effective circulation and maintain breathing then CPR need not be attempted. A patient cannot demand a treatment that is not clinically indicated. To provide CPR in such circumstances would be futile. The decision is a clinical one centred on the clinical picture at the time. The position should be communicated to the patient (see section 4.3) and, with consent, to those close to them.

#### 5.1.2 If the potential "adverse effects" of CPR outweigh any potential benefits

Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient. The patient's recently expressed wishes are very important to ascertain. Teams, in this case, should also consider whether a natural death free from the invasive intervention of CPR may be in the patient's best interests which could, with agreement, result in a Natural Anticipated and Accepted Death (NAAD).

### Audit point 4 – Consider the possibility of "NAAD / DNACPR"

All salient clinical aspects must be considered and discussed in order to help reach a clinically informed and a shared decision. It may be possible to conclude that the situation should be managed as a Natural Anticipated and Accepted Death (NAAD). NAAD is a "clinical concept" which may help clinicians and patients in partnership reach a shared position from which a DNACPR follows.

#### 5.1.3 When a valid and applicable Advance Decision to Refuse Treatment (ADRT) by CPR exists

**Patients should be asked at an early stage of contact if they have made an ADRT in relation to CPR.** There is an expectation that patients and/or their families will endeavour to ensure that healthcare teams are made aware of the existence and content of any specific Advance Decision. If there are reasons why the attending clinicians believe an Advance Decision to be invalid or inapplicable this must be carefully documented within the patient's record. When a patient is known to have a valid and applicable ADRT, at an appropriate time a DNACPR form should be completed. Where the existence of an Advance Decision is unknown with no time to investigate - the presumption is for attempting CPR, if this is considered to have a realistic chance of benefit.

### Audit point 5 – CPR-specific Advance Decisions – identification at point of contact

It is important to ascertain the existence of a specific ADRT for CPR at an early stage. This will ensure continuity of knowledge throughout the patient's journey and prevent inappropriate arrest calls.

#### 5.1.4 Status of a DNACPR decision in a high risk clinical intervention

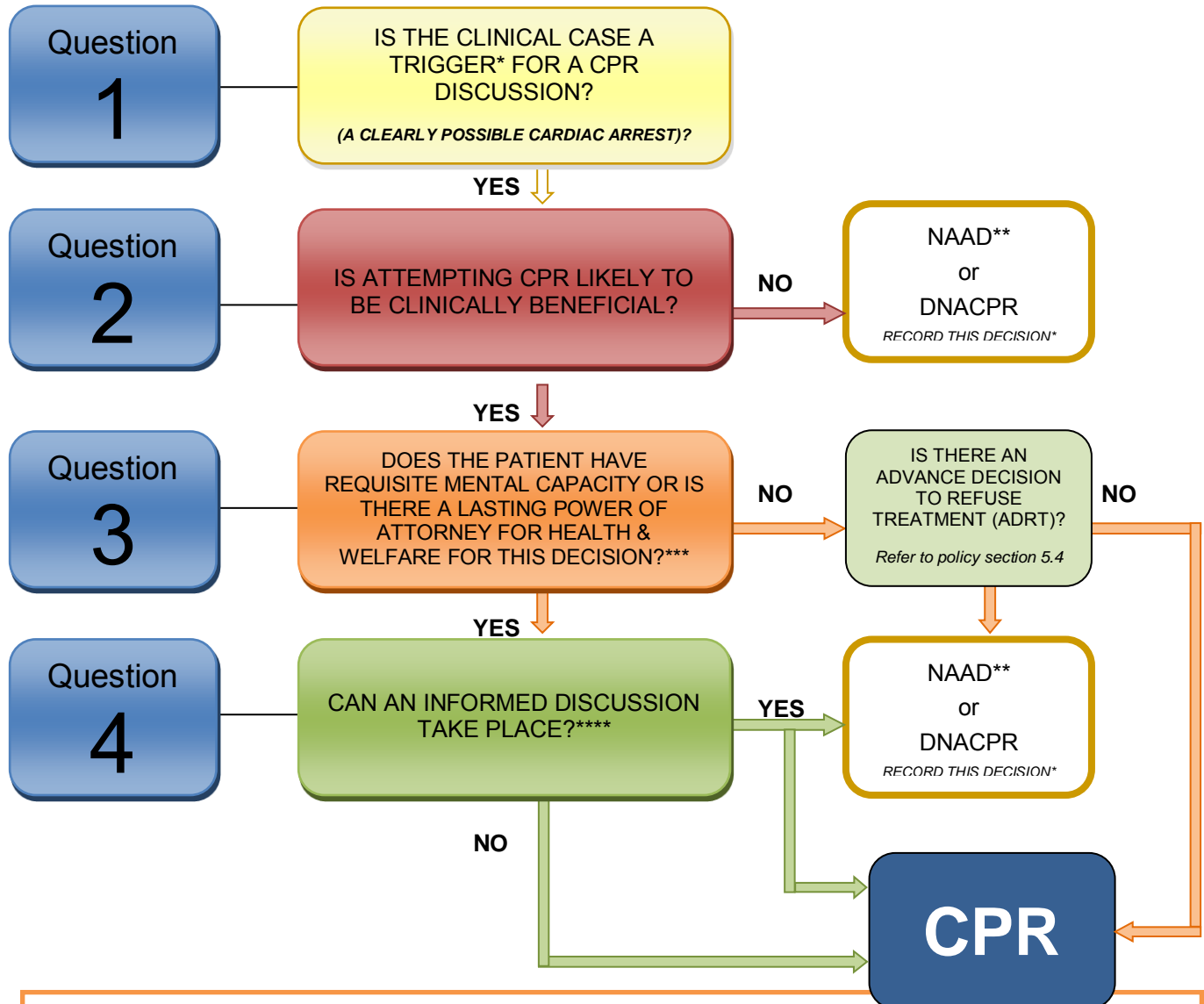
Any person over 18 years, who has the requisite mental capacity, can refuse treatment. If a patient with capacity refuses CPR, even when it may result in benefit, this must be carefully and clearly recorded in the patient's record. If a patient wishes a DNACPR decision to remain valid during a procedure or treatment that by its nature increases the risk of cardio-respiratory arrest (e.g. cardiac surgery), this will possibly impact on the risks of the procedure. If the clinician undertaking the

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procedure believes that the procedure or treatment will be too high risk with the DNACPR decision still in place then detailed discussion must take place. In some cases the higher risk will mean that it might be clinically reasonable not to proceed (see section 8.2).

5.2 Framework for a DNACPR Decision

**SCHEMATIC FRAMEWORK FOR DNACPR DECISION-MAKING**



**Note for clinicians - For details related to each box you MUST consult the accompanying complete All Wales DNACPR Policy**

**\*TRIGGER** – may represent a traditional ‘clinical trigger’ where the clinician envisages a possible cardiac arrest as a natural consequence of the condition – or when the harm or risks of CPR clearly exceed the benefit.

**\*\*NAAD** - See Policy Section 5.5.2.

**\*\*\*See Mental Capacity Act (2005) guidance paragraph 7.30– Health and Welfare Attorney must be designated to cover life-prolonging treatment decisions and be registered with the Office of the Public Guardian. If no ADRT is in place consider Section 5.4 relating to Mental Capacity Act.**

**\*\*\*\*Note that the patient may change his/her mind at any time. Also for interventions with significant risk of cardiac arrest, a CPR discussion must occur when obtaining informed consent for the procedure.**

5.3 How a DNACPR discussion should be conducted

**Workshop comment:**  
*“Approaching DNACPR sensitively can help alleviate a patient’s anxiety and a provide the family with comfort”*

The patient is *the priority* and must be at the centre of the discussion. For this reason, the initial approach made concerning DNACPR, must be with great tact, with sensitivity, and always with forethought to any communication and language needs. DNACPR discussions must be based on a spirit of candour, openness and trust armed with clear clinical knowledge of the patient. The approach to the discussion should always bear in mind the emotional needs of the patient and those most close to

them. **A DNACPR discussion should never be rushed and should be approached with recognition of the individual’s particular circumstances, values and beliefs.**

**Audit point 6 – A named individual for “close support”**  
Those closest to the patient (not always immediate family members) can provide valuable personal insight. It is essential for all patients to be asked to provide the name of someone they wish staff to deal with in the event of significant change in their condition and for this to be recorded.

**Audit point 7 – The DNACPR discussion (preparation, time and privacy)**  
Senior clinicians must allow adequate time for DNACPR discussions. They should possess knowledge of the patient’s history and the clinical evidence-base/rationale for the discussion. The conversation should be as private as circumstances allow. The conclusion should be understood by the patient. A nominated team-member should offer further contact with the patient to enquire if clarification is necessary.

5.4 DNACPR and mental capacity

The Mental Capacity Act (2005) defines the rights of patients and describes the responsibilities of those who provide care. It reinforces the understanding that people who lack the capacity to make their own decision about the specific issue at hand must remain at the centre of decisions that affects their lives.

*“It is vital to make every effort to hear the voice of those with reduced capacity” (Mencap Wales)*

Impaired function of the mind or brain is common in many medical conditions and care must be taken to ensure that those who assess decision making capacity have the appropriate level of skill.

Cases where capacity may be impaired demand a reflective approach from the senior responsible clinician. The first step in the process must be to perform a robust assessment of mental capacity. Whilst this can be performed by any clinician with the appropriate skill, in complex cases liaison psychiatry can sometimes be very helpful. Where the patient is found to lack capacity the current views of the patient should still, if possible, be taken into account as well as the views expressed before capacity was lost. Decision makers should also consult those closest to the patient. Where this is not possible and where there is no Lasting Power of Attorney (LPA) an independent mental capacity advocate (IMCA) should usually be appointed. This will help ensure that personally appropriate decisions are made and ensure independent safeguarding of the process (refer to the Mental Capacity Act and the Code for more detail).

**Workshop Comment:**  
*“For DNACPR – staff must be aware of, and address, any communication needs the patient might have”.*

A DNACPR decision must never be implemented purely on the basis that the patient lacks capacity. All NHS staff must take responsibility for applying the same standard in relation to DNACPR to all patients.

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If a patient lacks capacity and a decision is made in his or her best interests in accordance with the MCA then the clinical rationale and justification for the best interest decision should be clearly recorded in the notes by way of a best interest's balance sheet if at all possible.

#### Audit point 8: Raised awareness of the possibility of impaired mental capacity

A patient with altered capacity might display behaviour(s) not necessarily correlated with the usual clinical "reference points". In such cases, where DNACPR is being contemplated, input from those closest to the patient, carers and trusted friends is essential for understanding.

#### Audit point 9: Mental capacity and mental health

Clinical staff should also be aware of the effect that concurrent mental health conditions might impact on a patient's capacity. If it is felt that a significant psychological co-morbidity exists, specialist psychological assessment prior to DNACPR discussion should be considered.

### 5.5 Deciding that a case warrants a DNACPR decision

The DNACPR discussion framework is illustrated on page 11. This includes clinical events that might act as a "trigger" for a team-based DNACPR discussion. It also outlines questions clinicians should ask themselves in order to decide whether a clinical situation is one which might lead to a DNACPR discussion with the patient.

#### 5.5.1 DNACPR

In some cases it will be clear that the clinical position is irreversible and that a cardiac arrest is inevitable. Such circumstances for example could occur in the urgent acute setting or following the rapid irreversible decline of a known previously stable condition. The conclusion of the clinical team might be that it would not be in the best interests of the patient to attempt CPR. A DNACPR decision can then be made. Unless there is very good reason to the contrary, the clinical basis should be discussed with the patient and, with consent, also the individual chosen by the patient to be involved and a DNACPR decision with clinical reasoning clearly documented. Discussion with regard to organ and/or tissue donation should be considered in line with the current All Wales policy.

#### 5.5.2 NAAD (Natural, Anticipated and Accepted Death)

In less acute situations, a gradual decline in clinical well-being may be noted and ultimately death as a result of the current disease process may be envisaged. Accordingly, in the context of the patient's condition death might be considered to be clinically inevitable. The patient may or may not be receiving some care from palliative specialists. The team's reflection might be that death is the consequence of the disease process itself (natural) and is reasonably envisaged (anticipated) to occur in the near future.

#### Workshop Comment:

***"NAAD represents a tripartite system – recognising the natural course, one that is clinically envisaged and where there is an agreed, shared, position"***

When such a patient has capacity a discussion with the patient should take place, and if there is consent, with the person they have chosen to be involved in their care and treatment. A joint position on a Natural, Anticipated and Accepted Death (NAAD) may be the agreed shared position. NAAD is not a conclusion in itself. It would however represent a clinical position from which a DNACPR position follows. It is **NOT** a decision for the alteration of any other aspect of care and it should lead to further discussions as to how appropriate care can be achieved. **If a NAAD is reached, it is vital that it is conveyed to the patient and those closest to them that this would usually lead to a DNACPR decision, together with a clear explanation that "all clinically appropriate care will be provided"**.

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Many DNACPR decisions take place against a clinical context of chronic illness with gradual deterioration and multiple co-existing illnesses. In these circumstances, a planned fully informed discussion can take place. In all care settings the discussion must cover the risks and the burdens as well as the likely outcome from CPR. A mutual understanding of matters by the patient, those individuals close to them and the clinician is essential. A position of a Natural Anticipated and Accepted Death might be reached leading to a DNACPR decision.

### 5.5.3 DNACPR – for a patient with an ADRT

A patient aged 18 or over, may have a specific Advance Decision (ADRT) in place with previously expressed wishes withholding permission to attempt CPR in the event of cardiac arrest (see 5.2.3). Where known this information must be shared with the clinical teams caring for the patient. (An ADRT will come into force when a person lacks capacity. Otherwise they must be consulted normally)

A copy of the Advance Decision should be attached to the back of a completed DNACPR form. Where the patient lacks mental capacity and where no specific Advance Decision exists the default position is to provide CPR.

#### Audit point 10 – Involving relatives and those closest to the patient

**Teams must respect the knowledge and concerns expressed by those closest to the patient. Before discussing DNACPR patients should be asked if they want the support of a named person. If the patient declines this should be clearly recorded and a desire for confidentiality must be fully respected.**

### 5.6 Who should have the DNACPR discussion with the patient?

A senior team member should be nominated for the role. The professional undertaking the discussion should immediately record the discussion on the All Wales DNACPR form and ensure (if they are not the senior responsible clinician) that this is countersigned by the senior responsible clinician at the earliest possible opportunity/next ward round. **When the senior team member is a medically qualified professional the DNACPR will become active when signed, timed, dated and following entry of the GMC number (Section 5 - All Wales form). In all other circumstances sign off (with GMC number) by the senior responsible clinician is necessary for the DNACPR to be active (Section 6 - All Wales form).**

#### Audit point 11 – The All-Wales DNACPR form

**For DNACPR to be recognised in Wales (outside of a valid and applicable ADRT) the All Wales DNACPR form (see Section 6) must be completed. It forms the record of the DNACPR discussion. The clinician completing the form (when not the senior responsible clinician) must sign the form (Section 5 of form) and ensure countersignature by a senior responsible clinician as soon as possible (Section 6). A GMC number is essential for the form to be active.**

### 5.7 Requirements of the senior responsible clinician

A senior responsible clinician, in relation to this policy, must be available for all settings and will usually be a consultant or general practitioner. In some circumstances, senior nursing staff in secondary care and also in community settings may adopt some functions of this role in relation to this policy (but always with agreement and additional oversight by a senior responsible clinician).

#### They MUST:

- **Be clinically registered** and familiar with this policy.
- **Ensure appropriate involvement** has taken place both with the patient and those close to them.

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- **Ensure proper documentation** is in place.
- **Verify** a decision made on their behalf at the earliest possible opportunity by medical countersignature with GMC number.
- **Ensure communication of the decision** to the relevant clinical teams.

### 5.8 Senior oversight for every DNACPR decision

The senior responsible clinician will usually be the patients GP in the community or a consultant caring for the patient in secondary care. The senior responsible clinician is responsible for overseeing the documentation and communicating decisions. An agreed DNACPR position must be relayed to the senior responsible clinician in a timely manner, with information that a DNACPR discussion has taken place and an All Wales form completed.

**If this clinician is not physically present at the time of the discussion the fact they have been informed must be clearly recorded on the form.** The process of countersignature is not necessary if the senior responsible clinician has had the original discussion and completed the form. This process ensures senior clinical overview.

#### Audit point 12 – The DNACPR decision and oversight by a senior clinician

A senior responsible clinician should be made aware of, and countersign, the completed DNACPR form. Out-of-hours a senior clinician must be available and informed as soon as appropriate that a DNACPR discussion has taken place. In the acute situation the DNACPR discussion will often be undertaken (and the form completed) by the senior responsible clinician.

### 5.9 Responsibilities of the senior responsible clinician

The senior responsible clinician who countersigns the form is clinically responsible for the agreed position. This senior clinician has additional responsibilities: to ensure the correct communication of a DNACPR decision, and to help ensure (with other team members) that the needs of those closest to the patient are being met. The senior responsible clinician should also be the reference point for any significant clinical questions or difficulties that might arise relating to a DNACPR decision.

#### Workshop Comment:

*“Primary care must be made aware of all DNACPR decisions on their patients”*

## 6. The All-Wales DNACPR Form

### 6.1 Documentation of DNACPR decisions

The All Wales DNACPR Form is the only agreed form for recording new DNACPR decisions across NHS Wales after 1 October 2015.

**All** relevant sections of the form must contain entries. It specifically relates to DNACPR decisions and must form an integral part of the medical record. Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms must be adequately completed and contain up to date information. The form should be filled out in black ball-point, with legible handwriting and also signed, dated and timed.

*“The proper recording of discussions related to DNACPR is vital and engenders confidence in the system” (Older People’s Commissioner Wales)*

### 6.2 Whole-system recognition of the All Wales DNACPR form

The All Wales DNACPR form is recognised across all NHS sectors in Wales. When a DNACPR decision has been reached **a signed and dated copy of the All Wales DNACPR form must be**

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**handed to the patient**, or the person important to the patient / their advocate at the time and the original must be prominently placed in the patient's health record with copies relayed to other parties (see section 6.4).

### 6.3 The completed DNACPR Decision

A DNACPR decision is a specific clinical position that requires correct communication.

#### Audit point 13 – Completing the All Wales DNACPR form

**All sections of the form must have a clear entry. Senior responsible clinicians must check this is the case when initially informed and always prior to countersignature.**

### 6.4 Data capture and communicating the DNACPR Decision

Local Health Boards should ensure that the out-of-hours services, emergency departments and general practices have systems that can store, coordinate, manage and respond to DNACPR data. This should include a protocol for alerting the Welsh Ambulance Service when patient transport is requested for a patient with a current DNACPR decision.

***“The correct communication of DNACPR decisions is vital to meeting the patient's needs” –Welsh Ambulance Service Trust***

When a DNACPR decision has been reached in the hospital setting:

1. The **original form** should be prominently placed in the **patient's medical record**.
2. A marked **copy** should be **handed to the patient, the person important to the patient or their advocate at the time** for personal ownership prior to discharge.
3. A marked **copy** should be **forwarded to the patient's GP who should retain the paper copy and ensure that the DNACPR decision is recorded electronically on the patient notes. The GP must also inform the out-of-hours provider/the nursing/care home.**
4. A photocopy should be handed to ambulance personnel when transported from a hospital setting.

When a DNACPR form has been completed in the home or community setting:

1. The **original form** should be **retained by the patient's GP, who should place it in the medical record, record it electronically and inform the out-of-hours provider.**
2. A **marked copy** should be **handed to the patient or the person important to the patient or their advocate at the time for personal ownership.**
3. When relevant a **marked copy** should be retained in the records of the nursing/care home.
4. A **copy** should accompany the patient whenever care transfers to secondary care to be entered into their case record.

**Ambulance control should also be verbally informed of the existence of a DNACPR order at the time of booking an ambulance. Whenever possible a photocopy should be handed to ambulance staff when being transported.**

#### Audit point 14 – Communicating a DNACPR decision

**DNACPR decisions must be shared with clinical teams that are likely to be involved in a patient's on-going clinical care. Correct communication is essential. Processes for sharing DNACPR information must satisfy best information governance practice.**

**Communication with those closest to the patient must be unhurried, undertaken with patience, tact and with sensitivity for the situation.**

## 7. Review of a DNACPR decision

### 7.1 Review of a DNACPR decision

When necessary a review should normally be undertaken by a senior responsible clinician. When a review has taken place this should be recorded on the All Wales form.

A DNACPR decision review should always take place if one is requested by the patient. A review of the DNACPR decision should also be clinically considered when a patient's overall condition significantly improves warranting further discussion. The details of the review should be recorded in the patient's clinical record and the date recorded on the All Wales form. If the clinical circumstances **clearly** change a decision may need to be cancelled (see section 7.3) or a new form may need to be completed. This decision will be subject to the same information sharing as the initial decision ensuring the updating of all records with the new copy of the DNACPR form and, again, a copy of the new form must be handed to the patient or the person important to the patient or their advocate at the time.

### 7.2 Urgent DNACPR reviews

All patients must feel able to request a review of a DNACPR decision at any time. This includes those patients with reduced mental capacity, where either those close to them or named family members can request a review. **All such requests must have "urgent" status.** In some cases an unforeseen, sudden and *sustained* improvement in clinical status can occur and a review of the position may become necessary. In such circumstances, once clinically recognised, a review should take place.

#### Audit point 15 – DNACPR review

**All patients with an agreed DNACPR decision will be subject to a clinical review as part of the normal course of events. Efforts should be made to ensure that patients are aware that a request for review of a DNACPR decision can be made at anytime.**

### 7.3 Cancellation of a DNACPR decision

In some circumstances it may be appropriate to cancel a DNACPR decision. If this is necessary then the original form should be clearly crossed through with 2 diagonal lines in black ink with **"CANCELLED"** written between them. **The relevant section (section 7) of the form must also be completed and signed by a senior responsible clinician. All recipients of the DNACPR decision form (listed on the back of the original form) must be notified immediately that the decision has been as cancelled.** The communication must be in writing and logged in all relevant records and where possible contain a copy of the overwritten cancelled original document. The patient's copy of the original form should be returned and filed in an envelope in the case record to reduce risk. If destroyed (usually by shredding) this must also be recorded.

## 8. Special circumstances related to DNACPR

### 8.1 DNACPR decisions and high-risk invasive procedures

When individual patients are very unwell some pre-planned invasive procedures may substantially increase the risk of a cardio-pulmonary arrest (examples include: general anaesthesia, a pacemaker insertion, cardiac catheterisation, or surgical procedures). When such interventions are being contemplated for patients with an agreed DNACPR in place, the "current DNACPR position" must be reviewed with the patient in advance of the procedure. A decision to suspend the decision temporarily must be communicated with the patient or the patient's representative (if the patient has reduced mental capacity) and the wider clinical team and recorded.

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Some patients may want an agreed DNACPR decision to remain valid despite the increased risk of a cardio-pulmonary arrest and despite foreseen potentially reversible causes; others may agree that the DNACPR decision should be suspended temporarily. A decision as to how to proceed with the procedure in such cases is a matter for professional judgement and must follow informed discussion.

#### Audit point 16 – DNACPR case for automatic review - Example 1:

An agreed “DNACPR position” must be considered by the clinician undertaking an intervention that could impact on the risk of a cardiac arrest.

An agreed temporary change to the DNACPR status (covering the intervention and the immediate post-intervention period) must be clearly communicated to all relevant teams. Any new “temporary” position must also be included in “peri-operative checklists” and be communicated clearly to recovery teams.

The post-intervention clinical course must dictate when the original DNACPR position is re-established with all necessary teams appropriately informed.

### 8.2 Unpredictable, unforeseen and reversible clinical events

A DNACPR decision relates specifically to wishes expressed in the event of an *anticipated* cardio-pulmonary arrest. The decision applies only to CPR and not to any other aspect of treatment.

In clinical practice however unpredictable emergency situations can occur in patients who have a current DNACPR in place. These include for example, acute, unforeseen and immediately life threatening situations such as reversible anaphylaxis, choking or a completely blocked tracheostomy tube. In such instances the underlying cause requires maximal treatment and temporary CPR might become necessary whilst any reversible cause is correctly managed.

#### Audit point – 16: DNACPR case for automatic review – Example 2:

When clinical circumstances are NOT those envisaged during the original DNACPR discussion and in the event of an unpredictable acute and reversible cause of deterioration followed by cardiac arrest, the DNACPR decision does not override clinical judgement. Judicious senior clinical intervention is vital in such cases - with the clinical response subject to professional justification and review.

### 8.3 A clear request for CPR – when CPR is not clinically in the patient’s best-interest

A patient might insist that CPR is provided - even when (for clear clinical reasons) the clinical team feel it to be an intervention which cannot provide clinical benefit. When a patient requests CPR following a discussion that clearly outlines very significant risks and burdens, the senior clinician must record fully the patient’s expressed wishes alongside their own clinical views. **When conflict exists and whilst further advice is sought the interim position should normally be to provide CPR.** Efforts should quickly be made to reconcile the position if at all possible. In some cases a “team review” might resolve to respect the patient’s wishes in an individual case, and to provide CPR. In others however it might conclude that attempting CPR in the circumstances would be clearly contrary to best clinical judgement and good practice. In such cases, a second opinion must always be offered and legal advice may become necessary with further discussion with the patient. When there is serious challenge to a DNACPR position, from whatever quarter, the legal position must be considered. Healthcare professionals, who take a fully-considered ethical and clinical position, should immediately share and document their concerns and receive support from their organisation.

A close relative, named supporter or main carer might also openly express disagreement with a decision not to provide CPR. In such circumstances, you must respect and listen to the concerns. A review by the team should take place. If the original position of the team is upheld, then a second

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senior clinical opinion may occasionally be advisable depending on individual circumstances but with the knowledge and consent of the patient. However a relative's wishes cannot override the agreed position of the patient and the clinical team.

#### **Audit point – 16: DNACPR case for automatic review –Example 3**

**It should be considered an “exceptional clinical event” to pursue a DNACPR position that is contrary to the expressed wishes of the patient.**

**When a patient makes a request for “full CPR” that is clearly contrary to the unanimous judgment of the clinical team, this should be urgently re-considered by the clinical team and an attempt made to reconcile the position. A second senior clinical opinion should be considered. In exceptional circumstances legal advice may be necessary. All such cases should be subject to reflection at a later audit to facilitate team and organisational learning.**

### **8.4 Patients with Implantable Cardioverter Defibrillator Devices (ICDs)**

Patients with a DNACPR decision in place who also have an Implantable Cardioverter Defibrillator device (used to treat life threatening arrhythmias) require particular consideration. The decision as to when to deactivate the device requires careful planning and discussion between senior clinical colleagues (with expertise in ICD usage), the patient and those closest to them. In emergency situations teams must consult local policies or discuss with on call experts as to how to temporarily deactivate a device. All processes of informed consent and consultation with patient and close relatives apply to this element of care.

### **8.5 When clinical care extends between health sectors or across borders**

Holistic care spans health and social care sectors with teams working in partnership with patients. Clinical staff from different sectors ideally should, whenever possible, be involved at the beginning of the DNACPR process. Such input and team-working can prove helpful in deciding whether a DNACPR discussion is warranted and can assist future care across boundaries. The General Practitioner and wider primary care team can play a key role in this.

It is recognised that patients may be repatriated from cross-border providers. When a patient transfers to Wales with an active DNACPR decision, the All Wales DNACPR Form should be completed within 7 days. During that period the cross-border decision remains active.

When a patient is receiving out-patient or short-term (day) care across national borders then Local Health Boards in Wales must notify the other providers of the current local DNACPR status of a patient. If outpatient care is delivered outside Wales then teams initiating the clinical referral also have a clinical duty to inform providers of the position in advance of the outpatient or day-care appointment.

For in-patient stays, when patients are cared for outside NHS Wales, patients should have their DNACPR arrangements immediately reviewed in the new health-setting, subject to that provider's existing arrangements. Such patients will require support from their GP to instigate a review on discharge. For those in non-NHS settings they should be managed within the clinical governance arrangements of their long term placements which should be cognisant of, and ideally aligned to, the principles of this policy.

## **9. Training on DNACPR and community awareness**

A DNACPR training application, **emphasising the importance of good communication with patients and those closest to them**, should be placed on Local Health Board and Trust intranet systems. It should clearly outline this policy and facilitate access to further DNACPR information. Local Health Board junior doctor and nurse induction programmes across Wales must raise awareness of this policy. Primary care professionals must be offered access to training provided by Local Health Boards. It is vital that evidence is provided that this policy straddles the “whole system

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Approved by: All Wales DNACPR

Implementation Group

Owner: Dr Paul Buss

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of care” and hence all relevant NHS staff therefore should have easy access to knowledge bases, senior clinical support and to the training necessary in order to deliver an effective system for DNACPR. **The training needs to ensure awareness of the personal and specific nature of these decisions with awareness of the needs of patients.** It is also recommended that those clinicians undertaking senior responsible clinical roles across the NHS in Wales should undertake education on this DNACPR policy as part of their professional appraisal/revalidation cycle.

It is essential that those undertaking roles related to this policy in all community settings have access to practical work based training and education (provided ideally by Resuscitation Officers based within Local Health Boards). Training in such arenas should place some importance on the evidence and basis of knowing when NOT to provide CPR, as well as providing practical training on the performance of CPR. This training relates also to all ambulance staff with responsibility for the provision of CPR. A register should be developed and maintained of those individuals who have received training in DNACPR. Regulatory authorities for Wales should be made aware of this and might consider this as part of their monitoring of standards in community settings.

## 10. Measurement and Clinical Audit in NHS Wales

### 10.1 Audit of DNACPR in Wales

This All Wales DNACPR policy may have impact in a number of areas in relation to:

#### 10.1.1 Processes and NHS administration

- Access to (and deployment of) All Wales DNACPR Forms - across all sites
- Communication systems for DNACPR in place across the whole system of care
- Systems for collation of Serious Incidents and/or complaints and/or special reviews related to DNACPR issues (e.g. local mortality reviews, Coroner’s cases) – accessible, with documented learning and with links to professional appraisal
- Staff awareness of the DNACPR policy and access to DNACPR education and training

**“An effort must be made to cross reference incidents with complaints and investigations on DNACPR”  
(Dignity revolution)**

#### 10.1.2 Clinical and Professional aspects (Audit points 1-16)

- Decision making and appropriate use of NAAD/DNACPR
- Evidence of a correct assessment of mental capacity - when indicated
- Evidence for intention to consider advocacy and a health and welfare attorney in relation to DNACPR.
- Clinical aspects – appropriately completed and detailed DNACPR form
- Review of clinical communication (with learning events) about DNACPR involving all clinical teams (WAST, Emergency Department, Primary Care, Nursing Home etc.).
- Complex cases logged for shared learning and ongoing policy adjustment at annual national learning event.

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### 10.1.3 Communication and Teamwork

- Understanding responsibilities re: DNACPR roles within clinical teams
- Evidence of appropriate oversight by the Senior Responsible Clinician
- Evidence of MDT team decision making in the DNACPR process
- Evidence of correct communication across sectors including Primary Care, Out-of-Hours and emergency care systems

***“Whenever possible a DNACPR audit should include patient input” (Dignity revolution).***

### 10.1.4 Privacy, dignity and respect for patients and families

- Evidence of “spot check reviews” that decisions have been approached and reached with due regard for the patient’s dignity and in privacy
- Evidence of processes for special case DNACPR review
- Internal tests of communication, coordination and responsiveness re: DNACPR decision-making

*These elements should form the basis of a local DNACPR audit template. Local Health Boards following DNACPR implementation are expected to assess performance against these headings.*

## 11. References

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Decisions relating to cardio-respiratory resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing 3<sup>rd</sup> edition (1<sup>st</sup> revision) June 2016

Treatment and Care Towards the End of Life: good practice in decision making. General Medical Council. (2010)

Last Days of Life Care Pathway: <http://wales.pallcare.info/>

Time to Intervene: A review of patients who underwent cardio-respiratory resuscitation as a result of in hospital cardiac arrest NCEPOD (2012)

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**DNACPR Form (Adult) DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) DISCUSSION**

Date of DNACPR Discussion:	/ /
Date Reviewed	/ /
Reviewed by	
(Signature/GMC No)	

Surname: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 NHS/Hospital No: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Home Address: \_\_\_\_\_

WHILST ACTIVE, THIS FORM **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. Does the patient have capacity to make and communicate decisions about CPR? YES / NO  
 If "NO"  
 Are you aware of a valid Advance Decision to Refuse Treatment refusing CPR which is relevant to the current condition? YES / NO  
 Has the patient appointed a Health & Welfare Attorney to make decisions on their behalf? YES / NO  
 If "YES" they must be consulted.

2. Summary of the main clinical conditions and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: Tick all reasons that apply.

Clinical Summary:

**Reasons:**

- Not in the best interest/harm from CPR>benefit       This is a natural anticipated and accepted death   
 Patient refused CPR       Other (please elaborate in patient's healthcare record)

3. Has a discussion taken place with the patient? YES / NO  
 If CPR has NOT been discussed please clearly record reasons in the box below:

4. Has appropriate discussion taken place with those close to the patient, a Health and Welfare Attorney or an IMCA? YES / NO

Name of person: ..... Relationship to patient:.....

5. Healthcare Professional completing this form:  
 (Document is **ONLY** active when signed, timed and dated with GMC No.)

Name (PRINT): ..... Position: .....  
 Contact Details: ..... GMC No: ..... or NMC No: .....  
 (Nurse – form NOT active unless countersigned in box 6)  
 Signature: ..... Date: ...../...../..... Time:.....

6. Senior Responsible Clinician with oversight to sign below:  
 (Must inform MDT/others involved in the care of the patient of the decision – record the communication below)

Name (PRINT): ..... Position: .....  
 Contact Details: ..... GMC No: .....  
 Signature: ..... Date: ...../...../..... Time:.....

7. CANCELLATION of decision: NB: Cross form CLEARLY and write "CANCELLED" across form – notify ALL copy holders (see details below)

Name (PRINT): ..... Position: .....  
 Contact Details: ..... GMC No: .....  
 Signature: ..... Date: ...../...../..... Time:.....

8. COPIES of this DNACPR decision form have been sent to:

1.  Patient /Carer  
 2.  GP  
 3.  Nursing or Care Home

## **ALL BOXES MUST BE COMPLETED**

**In the event of a cardiac or respiratory arrest no attempts at cardio-pulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.**

- The patient's full name, date of birth and address must be **written clearly with ballpoint pen** or an addressograph must be attached to each copy of the form
- The date of completing the form must be entered.
- The decision must be communicated to all parties involved in the active care of the patient.
- The patient's clinical and DNACPR status should undergo routine review of circumstances. If reviewed please record at top of the form.

### **1. Capacity/Advance decisions**

If the patient does not have capacity please ensure that an **Assessment of Mental Capacity and Best Interests** is completed. Ensure that any Advance Decision (only valid for adults aged 18 or over) is specific and valid and applicable to the patient's current circumstances. Legal advice can be considered in the event of disagreements, as recommended in the All Wales policy. All other decisions must be made in the patient's best interests and comply with current law.

### **2. Summary of main clinical conditions and reasons why CPR would be inappropriate, likely to be unsuccessful or not in the patient's best interests.**

Please be as specific as possible. More detailed information can be recorded in the patient's healthcare record.

### **3. Summary of communication with patient**

State clearly what was discussed and agreed. If the decision was NOT discussed with the patient clearly state the reason why. If an interpreter is used they must be approved by the organisation.

### **4. Summary of discussion with those close to the patient (e.g. spouse/partner, family and trusted friends, carer, or advocate)**

If the patient does not have mental capacity those close to the patient must be consulted and may be able to help by indicating the patient's recent wishes. They **cannot** make the decision to withhold cardio-pulmonary resuscitation - this is a medical decision. If the patient has made a Lasting Power of Attorney for Health & Welfare, ensure that it is registered. If the patient has appointed a Health & Welfare Attorney to make decisions on their behalf, that person must be consulted. A Health & Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity - ensure that discussion with others is with their consent and does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes.

### **5. Healthcare professional completing this DNACPR form**

This will vary according to circumstances and local arrangements. This should be a senior member of the clinical team. **The form becomes active when a medical professional signs, times and dates the form and provides their GMC number.**

The decision must be overseen by the senior responsible clinician (usually the patient's Consultant or General Practitioner) at the earliest opportunity. If the senior responsible clinician is NOT the doctor initially completing the form, they must be informed as soon as reasonably possible. If a review of circumstances around the DNACPR form is necessary, this should be undertaken in line with the all Wales policy. **Any review of the decision is subject to communication requirements as outlined in All Wales policy.**

### **6. Details of the senior responsible clinician involved in the decision**

Ensure all details (name and position) are completed (see All Wales policy) and that the DNACPR decision is communicated to all those involved in the patient's care as in All Wales policy.

### **7. Cancellation of the decision**

Ensure all details are completed. The form should be crossed through diagonally using 2 lines and "**CANCELLED**" should be written clearly between them, and signed and dated by the doctor cancelling the decision. The cancelled form must be filed within the current clinical record and this should be communicated to all copy holders below - as per All Wales policy.

### **8. Communication of the Decision**

Ensure communication of the DNACPR decision. Wherever possible the patient (or person closest to the patient) should receive a copy of the completed form ideally in Welsh and English. If completed in a hospital setting a copy of the form must be sent to the GP on discharge. If completed in the community setting you must communicate the decision to OOHs and/or nursing/care home if relevant.



**Key contributors to this revision of this policy:**

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