


DNACPR

(Do Not Attempt Cardiopulmonary Resuscitation)

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Policy Statement

The policy needs to be implemented in the contexts of the care of terminally ill people, their palliative care, symptom and pain control, and in cases of sudden collapse and medical emergencies.

The policy also aims to be consistent with the Code of Practice developed under the Mental Capacity Act 2005, since people in need of resuscitation by definition might also be lacking capacity at the time to take key decisions on their subsequent treatment.

Because of the Tracey Judgement in 2014, all NHS trusts have a legal duty to consult with, give the individuals with capacity opportunity to express their views and inform the individual if a DNACPR order is placed on their records. As an organisation, we confirm with our residents and/or their responsible person that they are aware that a DNACPR is in place and have had opportunity to discuss their views. This is an integral part of respecting an individual's dignity.

The Policy

This organisation works on the basis that everyone has the right to make choices and decisions about their treatment in the event of their needing to be resuscitated, and that these wishes should be respected if the situation arises.

As far as possible people's wishes should be ascertained and recorded as 'advance decisions' (a term used in relation to the *Mental Capacity Act 2005*) on their service plan, taking into account that this process will require sensitive and careful handling.

The person's capacity to take an advanced decision for her or himself regarding their possible resuscitation also requires consideration. For example, if there is any doubt about the validity of an advanced decision then it would be incumbent to attempt resuscitation or to seek medical help to do so.

If it is clear that the person has made an advance decision against being resuscitated under certain conditions then this needs to be respected, as should any associated wish such as keeping the decision confidential from relatives and others.

This organisation may need to clarify its ethical and legal position in cases, for example, where there are doubts about a person's mental capacity to make advance decisions, or where there are doubts about the authenticity of any representation of the person's views. (In such instances there can be no reasonable belief that the person has taken such an advanced decision and attempts at resuscitation would then follow)

Procedures

- ☞ This organisation attempts to elicit from all of its residents, in relation to its contractual obligations to them and their care planning, whether:
 - a) They have made an advance decision regarding their treatment, and if so whether this decision has been lodged with their medical practitioner
 - b) They might wish to make such a decision.
- ☞ This organisation ensures such issues are dealt with, particularly in situations where there is a clear risk that the resident could require resuscitation at some point;
- ☞ This organisation will clearly communicate to the resident and their representatives its expectations of what its staff should do under those circumstances. These are recorded on the resident care plan;

- ☞ In incidents of sudden or unexpected collapse, where a person has clearly not made any advanced directive or given any indication of their views on resuscitation, the organisation expects its staff to take all necessary steps to seek emergency help as promptly as possible;
- ☞ In all cases, organisation staff are instructed to summon medical help and the emergency services without delay;
- ☞ It is the policy of this organisation that no attempts at resuscitation are undertaken by its staff; however, they are expected to provide usual standards of help and comfort, e.g. pending the arrival of the emergency services or medical help;
- ☞ This organisation takes resuscitation and emergency care into account when allocating staffing resources; however, it cannot be guaranteed that staff will be fully competent or qualified to provide resuscitation, in any given emergency situation, it cannot be guaranteed that staff will be fully competent or qualified to provide assistance in any given emergency situation, hence the emergency services will always be called; further interventions will then be directed by the medical practitioner and/or paramedical practitioners. If organisation staff are aware that the ill person has made an advance decision, or there is a reasonable belief that they do not wish to be resuscitated, then they should pass this information to the medical team;
- ☞ All staff receive guidance and learning opportunities to clarify their attitudes and feelings over such issues and to understand their respective roles and responsibilities in such situations.

Note:

- ! An 'advance decision communicates the sort of treatment a person wants for different levels of illness, such as a critical or terminal illness, permanent unconsciousness or dementia in the event of their losing the capacity to communicate their wishes at the time. As a document an advance decision might include a number of specific advance decisions, of which being either for or against resuscitation might be included.
- ! An advance decision indicates to medical doctors and health care professionals that the person does not want certain types of treatment, such as to be put on a ventilator if in a coma. But it can also say that the person would like a certain treatment, or to receive whatever treatment is available that might keep the person alive.
- ! An advance decision only comes into effect when a person is terminally ill (which generally is held to mean less than six months to live), e.g. with widespread cancer. An advance directive does not let the person choose another person to make decisions for them, unless it specifically appoints a proxy.

Training Statement

All staff are trained in DNACPR procedures on an individual resident basis.

Related Policies

Advanced Care Planning

Advocacy

Autonomy and Independence

Consent

Death of a Resident

Deprivation of Liberty Safeguards

Dignity and Respect

Meeting Needs










Mental Capacity Act 2005

PRACTICAL GUIDE ON HOW TO DISCUSS DNACPR ORDERS WITH SERVICE USERS

In the case of a mentally competent service user the decision not to resuscitate should be discussed with the service user unless this is deemed inappropriate by the staff. When the service user is mentally competent, a discussion with relatives/carers should only take place with the individual's permission. If the service user is mentally incompetent, discussion with relatives/carers should take place subject to consideration of the individual's current or previous wishes. Due regard should be given to service user confidentiality at all times. If there is an advanced directive, this should be considered. Whilst discussion with relatives is important, the final decision regarding resuscitation is a medical one based upon the individual's best interests, save where there is a

valid advanced directive. Good communication is paramount. The service user should be given as much information as possible about the CPR procedure and possible outcomes.

Clinical staff often fear undertaking such discussions but, when carefully done, the service user is rarely distressed. Many service users have strong views and are relieved that staff have raised these issues. Such discussions should improve, not detract, from a healthy trusting relationship. It may be appropriate to initiate any discussion with a general question as to whether the service user has any particular view or concerns about their illness and its treatment. They might also be asked as to whether they have ever completed an advance directive/living will. Giving them the opportunity to discuss things, if they wish, is very different from a doctor or nurse determined agenda.

1. **Decide** whether a discussion about resuscitation is appropriate.
 - a) When to discuss a DNACPR order:
 -  If a mentally competent service user indicated he/she wishes to discuss CPR.
 -  If CPR is thought to have some chance of success in a mentally competent service user who is perceived to have a poor quality of life.
 -  When the basis of a DNACPR decision is the absence of any likely medical benefit, discussion should aim at securing an understanding and acceptance of the clinical decision that has been reached. This would involve discussing for example palliative management and overall prognosis.
 - b) When **not to** discuss a DNACPR order:
 -  If discussion is likely to be detrimental to the service user's wellbeing e.g. if the service user is depressed.
 -  If a mentally competent service user indicates he/she does not want the discussion.
 -  If a service user is deteriorating such that he/she is in the dying phase of their illness.
2. **Setting** - Ensure sufficient privacy and that those whom the service user wants to be involved are present. Do not stand above the service user. If the service user does not mind, it is often helpful to have a member of the nursing staff present. They often help with questions, support and reinforcement after the staff have left.
3. **Raising the topic** One suggestion: "We would like to discuss with you what you would want us to do if you become too sick to talk with us." "One important issue is the question of resuscitation. Although it is unlikely to happen, we need to consider what we should do if your heart should stop." "Some people have strong views about how much treatment they should receive if they become very sick – I wonder if you have ever thought about this."
4. **Timing** Shortly after a diagnosis is not normally a good time to discuss treatment limitation, although it may be necessary. The discussion is probably best done when the diagnosis and prognosis are clear and when the service user has come to terms with their diagnosis.
5. **Seek** to establish the service user understanding of the current situation, the nature of resuscitation, its likely outcome and his or her expectations and desires. Service users and families often have unrealistic expectations of the value of resuscitation.
6. **Provide information** on CPR in lay terms and check understanding. The rate of delivery of information should be judged from the individual service user's response and understanding. Give the service user the information leaflet (appendix 1) for further reference.
7. **Provide an explicit** recommendation if that is what the service user wants although making the basis of your recommendations clear. "My opinion may be different from what you want us to do. That is why I am talking to you about this."
8. **Try to understand:**
 -  the individual's views
 -  the individual's values which inform those views
 -  their scope of application (e.g. what treatments they relate to).
9. **Record** the individual's views, values and scope in care notes.
10. **Discuss** decisions about CPR in the positive context of supportive care. Many service users fear abandonment and pain more than death. Clinical staff need to emphasise which treatments are still actively being pursued, plans to visit regularly, control pain and provide other measures for ensuring comfort. It is important to separate the decision not to resuscitate from decisions about other healthcare.
11. The decision to attempt resuscitation (or not) is not set in stone and can change over time dependant upon the circumstances.