Briefing Paper

1. Introduction

The purpose of this paper is to provide the Health Overview and Scrutiny Committee with some background information regarding Cardiopulmonary Resuscitation (CPR), the Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Form including its implementation and Living Wills to help them with their review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and their use and effectiveness.

2. Cardiopulmonary Resuscitation (CPR) – What it is and what it is not

"When someone suffers sudden cardiac or respiratory arrest, CPR attempts to restart their heart or breathing and restore their circulation. CPR interventions are invasive and include chest compressions, electric shock by an external or implanted defibrillator, injection of drugs and ventilation"[1]. The level and speed of interventions given will depend on the patient's location at the time of cardiac or respiratory arrest.

CPR measures do not include analgesia, antibiotics, drugs for symptom control, feeding or hydration (by any route), investigation and treatment of a reversible condition, seizure control, suction, or treatment for choking.

3. Potential Outcome of CPR

"In reality, the survival rate after cardio respiratory arrest and CPR is relatively low. After CPR for cardio respiratory arrest that occurs in hospital, the chances of surviving to hospital discharge are at best about 15-20%. Where cardiac arrest occurs out of hospital, the survival rate is lower, at best 5-10%. The probability of success depends on factors including the cause of the arrest, how soon after the arrest CPR is started, and the equipment and staff available to deliver it.

[1] Treatment and care towards the end of life, General Medical Council, 2010

Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture, or prolonged treatment in an intensive care unit (ICU), possibly including prolonged artificial ventilation"[2].

4. Post CPR Period

"In the immediate post-CPR period most patients require at least a brief period of observation and treatment in an ICU or a coronary care unit (CCU) or both. Some patients will require treatments such as artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump. It is not uncommon for difficult decisions about CPR to arise in respect of patients for whom it may be possible to re-start the heart after cardiac arrest but for who admission to an ICU for continued organ support would be clinically inappropriate because they would be unlikely to survive their admission to the ICU.

There is also a risk that the patient will be left with brain damage and resulting disability, especially if there is delay between cardio respiratory arrest and the initiation of the CPR. Some CPR attempts may be traumatic, meaning that death occurs in a manner that the patient and people close to the patient would not have wished"[3].

5. When to consider making a DNACPR decision

The General Medical Council supports the use of a DNACPR decision if:

- The decision is based on the circumstances of the individual patient
- It is the patient wish/choice not to have CPR
- Cardiac or respiratory arrest is an expected part of the dying process and CPR will not be successful
- It will help to ensure that the patient dies in a dignified and peaceful manner

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[2] Decisions relating to cardiopulmonary resuscitation, A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2007

[3] Decisions relating to cardiopulmonary resuscitation, A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2007

- The potential outcome of CPR may be successful but the benefits of prolonging life is outweighed by the burdens and risks

In situations whereby the patient requests CPR in spite of a small chance of success or the judgement that it would be clinically inappropriate, the General Medical Council provides advice on how this should be handled and concludes that "when the benefits, burdens and risks are finely balanced, the patients request will usually be the deciding factor." However, "the medic is not obliged to agree to attempt CPR if it is considered not to be clinically appropriate"[4]

6. What is a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form?

The DNACPR form is a means of communicating a DNACPR decision (an advanced decision specific to CPR) that has been made by a senior doctor (e.g. Consultant, GP) who has responsibility for the patient or a health care professional who has undertaken the necessary training to make the DNACPR decision or by the patient, to those who may encounter the patient in the event of a cardiopulmonary arrest.

The presence or absence of a DNACPR form should not override clinical judgement about what will be of benefit to the patient in an emergency (e.g. choking, anaphylaxis, sepsis etc).

7. Variants of DNACPR forms

Unlike Scotland, England doesn't have a national DNACPR Policy, DNACPR form or Website. In England DNACPR policies are created locally by the care provider and this has led to a number of variants of the DNACPR form. Historically these forms were only valid in the care facility that issued it and did not travel with the patient.

Therefore care providers in Yorkshire and Humber have been working on an approved DNACPR form which will be the agreed form for recording the DNACPR decision, within the Yorkshire and the Humber region.

[4] Treatment and care towards the end of life, General Medical Council, 2010

8. Yorkshire and the Humber Regional DNACPR Form

The aim of the initiative was to establish a common form and protocol to be used across the region to ensure that DNACPR decisions made for a patient, or by the patient, are documented and communicated effectively.

Work had already commenced at Airedale General Hospital (AGH) in 2009 to review their Do Not Attempt Resuscitation (DNAR) form against the one developed by NHS Lothian. The reason the NHS Lothian template was used as the model form was because its design took into consideration the need to ensure that the form was transferable across care settings.

AGH then engaged with NHS Bradford and Airedale with the aim of agreeing a joint policy to support the transferable form and a local working group was formed to achieve that.

In August of 2009, as a result of feedback given at NHS Bradford and Airedale's Clinical Review Group meeting with Yorkshire Ambulance Service (YAS), it was decided that the issue of the multiplicity of DNAR forms within Yorkshire and the Humber needed to be addressed in order to resolve some of the problems it presented to YAS.

As lead commissioner for YAS, NHS Bradford and Airedale took ownership of the proposal and a bid was submitted to NHS Yorkshire and the Humber to secure financial support from the Regional Innovation Fund.

Once the regional working group was established the DNACPR form now in use across NHS Bradford and Airedale was reviewed against the template recommended by the Resuscitation Council (UK).

The feedback from clinicians regarding the Resuscitation Council template was as follows:

- It didn't request an explanation as to why CPR would be inappropriate
- It was interpreted as a record of a decision being made by the patient
- It didn't include any guidance
- Section 2 did not distinguish between inappropriate, unsuccessful or not in the patients best interests

- The design of the form did not facilitate its transferability of use to patient transfer services or to other care settings

It was agreed that the current NHS Bradford and Airedale model had been tried and tested and therefore was selected as the template from which the regional DNACPR form would evolve.

The regional DNACPR form is:

- Applicable to adults over 16 years old
- Transferable from one care setting to another
- Consistent with the
    - Decisions relating to Cardiopulmonary Resuscitation. A joint statement from the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) 2007
    - Treatment and care towards the end of life: good practice in decision making. General Medical Council (GMC) Guidance July 2010
    - Advice statement on resuscitation Nursing and Midwifery Council (NMC) May 2008
- To be in accordance with mental capacity act, safeguarding adults/children

An example of the latest version of the Yorkshire and Humber regional DNACPR form is at appendix A.

9. Roll out of the Regional DNACPR Form

NHS Bradford and Airedale set up a Regional DNACPR Project Board and Regional DNACPR Strategic Working Group which had representation from partner organisations across the Yorkshire and Humber region. Representation on these groups included the Lead Resuscitation Officer from York Teaching Hospitals NHS Foundation Trust and Community and Mental Health Services, NHS North Yorkshire and York, as well as a Commissioning Manager from NHS North Yorkshire and York.

Prior to roll out of the regional DNACPR form, NHS North Yorkshire and York had discussions with and/or wrote to its care provider colleagues. These included:

- Chief Executives of Acute Hospitals
- Managing Director of Community and Mental Health Services, NHS North Yorkshire and York
- Local Medical Council
- Local Authorities
- Hospices
- Independent Care Group
- End of Life Locality Groups
- Cancer Locality Boards

Just prior to the roll out of the regional DNACPR form, care provider colleagues were also invited to a meeting to:

- Understand the current arrangements
- Understand the proposed arrangements
- To finalise the NHSNYY's roll out plan
- To address any outstanding concerns or issues

NHS North Yorkshire and York started rolling out a new single 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Form v11 in September 2010'. This was quickly adopted within Community and Mental Health Services (including Out of Hours Services) and GPs, Hospices, Local Authorities, and Independent Care Homes but was more problematic in some acute settings.

To overcome concerns in the acute setting staff were invited to a workshop and contributed to discussions on how the form could be amended to make it more user friendly in an acute setting and this lead to version 12 of the form being published in July 2011.

An education package was compiled by members of the Strategic Working Group and consisted of:

- PowerPoint training presentations
- DVD/webcast of doctor to doctor and doctor patient/simulated DNACPR conversations
- CPR Patient information leaflet

These implementation aides and training tools were provided to all organisations to assist with their implementation programme. However, each organisation managed their implementation in accordance with their own project plan and time table.

As roll out progressed staff were given the opportunity to participate in an online survey regarding the roll out of the regional DNACPR form. The results show this opportunity was well received by staff within the NHS North Yorkshire and York patch.

During the introduction of the regional DNACPR form there have been a small number of cases reported across the region where the form was not adhered to. Reported incidents have been investigated and all necessary action taken which includes cascading any lessons learnt from the incident to relevant staff groups to prevent the problem arising again.

10. How does the Regional DNACPR form work?

The regional DNACPR form is adopted by the care provider and incorporated into their DNACPR policy.

The regional DNACPR form is completed using the guidance provided on the reverse of the form, a framework for making a CPR decision from the care provider's local DNACPR policy and/or at the patient's request. Other guidance such as treatment and care towards the end of life (General Medical Council, 2010) and decisions relating to cardiopulmonary resuscitation (A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2007) is available to staff when considering a DNACPR decision.

It is the responsibility of the healthcare professional completing the form to ensure that the DNACPR decision is communicated to all who need to know.

Whilst the patient is in hospital, the DNACPR form should remain in front of the case notes or kept in accordance with local hospital policy.

In all other care settings the DNACPR form should be located in the front of the care record/nursing record or kept in accordance with the care providers DNACPR policy.

If no nursing record exists in the home, the patient/family/carer will determine the best place to store it, and communicate this to the health care professionals.

As patients move between care settings, the DNACPR form moves with the patient in a clearly marked envelope. Ambulance control should be informed that a DNACPR form exists at the time of booking a patient transport services (PTS) ambulance or when requesting an emergency ambulance.

11. Who recognises the regional DNACPR form?

The regional DNACPR form is recognised by all health care providers and Yorkshire Ambulance Service in the Yorkshire and Humber region.

12. What is the difference between a DNACPR form and a Living Will?

DNACPR Form

A DNACPR form is an approved document used by care providers to record an advanced decision. The document is limited to the withholding of one treatment only i.e. Cardiopulmonary Resuscitation.

Validating a Regional DNACPR form

Having one regional DNACPR form makes it easier for staff to validate the form quickly. For the form to be validated it must be:

- Completed correctly
- Current i.e. not exceeded any review date set by the person making the DNACPR decision or in accordance with local DNACPR policy if a review date hasn't been set
- Signed by an appropriate person
- An original form with an ink signature

Living Will

A Living Will (also known as Advance Decision in England and Advanced Directive in Scotland) is a document which sets out the future medical wishes of an individual should they become terminally ill or require medical treatment at a time when they do not have the full mental capacity to make those relevant decisions.

The term 'Living Will' can be divided into two categories, Advanced Statement and an Advanced Decision. An Advanced Statement is purely informative and must be fully respected by health care professionals, it outlines the extent of medical intervention that the individual would like whereas an Advanced Decision is legally binding and details the individual's right to refuse any form of treatment from antibiotic medication to intravenous feeding and resuscitation.

In England, Wales and Scotland a Living Will is considered to be a legally binding document which must be respected by all medical professionals. However, this is not the case in Northern Ireland.

A Living Will will only be valid (accepted legally and by health care professionals) if the document has met a number of criteria which include that the individual:

- Was 18 or over and had capacity when they made it
- Has set out exactly which treatments they don't want in future (if they don't want life-saving treatment, their decision must be signed and witnessed)
- Has explained the circumstances under which they would want to refuse this treatment
- Has made the advance decision without any harassment by, or under the influence of, anyone else
- Hasn't said or done something that would contradict the advance decision since it was made

Because of the potential complexity of a Living Will, it is anticipated that individuals may have sought advice and have discussed their Living Will with their GP, or other treating health care professionals while they have the capacity to do so.

To ensure compliance to the Living Will all care providers will need to be aware of the Living Will and would have to have satisfied their selves of its validity.

Validating a Living Will

This can be difficult as there is no set format for a Living Will. If the person providing treatment is aware of a Living Will, they must then consider whether it is valid and applicable to the particular circumstances.

When deciding whether a Living Will is valid, the person providing the treatment should try to find out if the patient has:

- Withdrawn the decision since they made it, at a time when they had the mental capacity to do so
- Done anything which is inconsistent with the decision and suggests that it no longer represents their wishes or
- Made a Lasting Power of Attorney, giving someone else the authority to make the decision consenting to or refusing the particular treatment

When deciding whether a Living Will is applicable to the particular circumstances, the person providing the treatment must also:

- Assess whether the patient actually still haves the mental capacity to make the particular decision about their treatment at the time it has to be made (they must start from the assumption that you have capacity and the advance decision will only be relevant if there is evidence that this is not the case)
- Check that the treatment and circumstances are the same as those referred to in the decision
- Consider whether there are any new developments that the patient didn't anticipate when they made their decision, which could have affected their decision; for example new developments in medical treatment, or changes in their personal circumstances.

Professionals providing medical treatment are protected from liability for not providing treatment if they reasonably believe there is a valid and applicable Living Will.

Health Care Professionals can provide treatment if they are in doubt over the existence, validity or applicability of a Living Will, and they are again protected from liability.

13. Further Reading

This paper only briefly touches on Living Wills and due to the complexity it is recommended that the Health and Overview Scrutiny Committee may wish to seek further advice to ensure clarity over the legal standing of this type of documentation. A number of useful websites/documents are as follows:

National End of Life Care Programme
www.endoflifecareforadults.nhs.uk/publications/pubadrtguide

Directgov UK
www.direct.gov.uk/en/Governmentcitizensandrights/Death/Preparation/DG_10029429

AgeUK
www.ageuk.org.uk/money-matters/legal-issues/living-wills/

Many of the quotes made in this paper have been taken from the following documents:

Decisions relating to Cardiopulmonary Resuscitation. A joint statement from the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) 2007.
www.rcn.org.uk/__data/assets/pdf_file/0004/108337/003206.pdf

Treatment and care towards the end of life: good practice in decision making. General Medical Council (GMC) Guidance July 2010
www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

12 December 2011

Appendix A

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over v12 June 2011

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		
Address		Relationship
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR: Select as appropriate from A - D (see reverse)

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

A. ☐ **CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.**

B. ☐ **CPR is against the wishes of the patient as recorded in a valid advance decision**
The right to refuse CPR in an Advance Decision only applies from the age of 18.

C. ☐ **The outcome of CPR would not be of overall benefit to the patient and:**
i) They lack the capacity to make the decision ☐ **or**
ii) They have declined to discuss the decision ☐
This must be discussed with relevant others wherever possible (details overleaf)
This **has** been discussed with ..... (name) Relationship to patient:.....

D. ☐ **CPR would be of no clinical benefit because of the following medical conditions:**
.....
Even in situations in which CPR is not expected to be successful, it is still good practice to explain to the patient and/or relevant others why CPR will not be attempted.
This **has** been discussed with the patient ☐
This **has not** been discussed with the patient because it would cause them unnecessary distress ☐
This **has** been discussed with ..... (name) Relationship to patient:.....

Section 2 Healthcare professionals completing DNACPR form (see reverse)

Name & Designation	Name & Designation (Counter Signature if required)
Organisation	Organisation
Signature Date	Signature Date

Section 3 Review of DNACPR decision (if appropriate)

This order is to be reviewed by: Date: .....

Review Date	Full Name and Designation	Signature	Still applies	Next Review Date
			☐ (tick)	
			☐ (tick)	

AMBULANCE CREW INSTRUCTIONS

If Cardiopulmonary Arrest occurs, please do not attempt CPR. All other appropriate treatment should be given.
Any other specific instructions: .....

These guidelines are based on an agreement within the Yorkshire and Humber region.
For more details refer to your local policy relating to DNACPR.
This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (*Please write legibly and with black ink*)

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility*

Option C

1. The term "*overall benefit*" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "*best interests*" as defined by the Mental Capacity Act, 2005.
2. This situation **must** be discussed with relevant others where possible. Record details of your discussion in the patient's notes.
3. The term "*relevant others*" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D

Record underlying condition/s eg poor Left Ventricular function, end stage obstructive airway disease, disseminated malignancy with poor performance status.

Section 2 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Section 3 Review – In accordance with your local Policy.

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (eg hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing **CANCELLED** in large capitals and adding your signature and date. It should then be filed in the patient's notes.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare professional completing the form to ensure that the DNACPR status is communicated to all who need to know.

For patients being transferred between different care settings, it is essential that all professionals including Out of Hours (OOH) and Ambulance (e.g. Yorkshire Ambulance Service) are made aware of this DNACPR order

1. Send the **original form** with the patient.
2. A photocopy should only be retained in the patient's notes for audit, marked with the words '**COPY**' in large capitals, signed and dated.
3. In circumstances where patients are being transferred to community: the DNACPR status should be communicated to patient (if appropriate) and *'relevant others'*. They may prefer the form to be placed in a clearly marked envelope.
4. For discharges to community settings: communicate to the GP, Out of Hours service, and any other relevant services as appropriate e.g. Hospice.

v12 June 2011
Regional Review Date: June 2013
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