



Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

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1. Introduction

The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, then that treatment is no longer justified (BMA, RC (UK) RCN 2007).

Survival following cardiopulmonary resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Whilst patients who have an acute event, such as a myocardial infarction, may recover with CPR, the chances of survival are much lower for patients who have a cardiopulmonary arrest due to progression of a life limiting condition. Eighty percent of cardiac arrests occur outside hospital and 90% of these will result in death. When cardiac arrest occurs in hospital, 13-17% survive to hospital discharge and many of these will have long term disability.

Cardiopulmonary resuscitation could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically CPR could be used on every individual prior to death. It is, therefore, essential to identify patients for whom cardiopulmonary arrest represents the terminal event in their illness and for whom CPR is inappropriate. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to ensure that if death occurs there is no added loss of dignity. It is also essential to identify those patients who would not want CPR to be attempted in the event of a cardiorespiratory arrest and who competently refuse this treatment option.

2. General Principles

- 2.1 This policy is intended to prevent inappropriate, futile and/or unwanted attempts at cardiopulmonary resuscitation for adult patients (aged over 16 years) in all care settings across Lincolnshire. It does not refer to other aspects of care, for example, analgesia, antibiotics, suction, treatment of choking, treatment of anaphylaxis or other interventions which are sometimes loosely referred to as “resuscitation”.
- 2.2 This policy applies to all of the multidisciplinary healthcare team involved in the patient’s care.
- 2.3 Variations in local policies can cause misunderstandings and lead to distressing incidents for patients, families and staff. Increased movement of patients and staff between different care settings makes a single, integrated and consistent approach to this complex and sensitive area a necessity. Therefore, agreement has been reached across providers to use a single DNACPR form and policy.
- 2.4 Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

- 2.5 If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.
- 2.6 For many people anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.
- 2.7 Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.
- 2.8 If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.
- 2.9 Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or of those close to the patient. However, there is a presumption in favour of informing a patient of such a decision. The patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.
- 2.10 For a person in whom CPR may be successful, when a decision about future CPR is being considered there should be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best-interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision-makers.
- 2.11 If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable Advance Decision Refusing Treatment (ADRT), specifically refusing CPR, this must be respected.
- 2.12 There should be clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them.
- 2.13 Any decision about CPR should be communicated clearly to all those involved in the patient's care.
- 2.14 Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.
- 2.15 Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

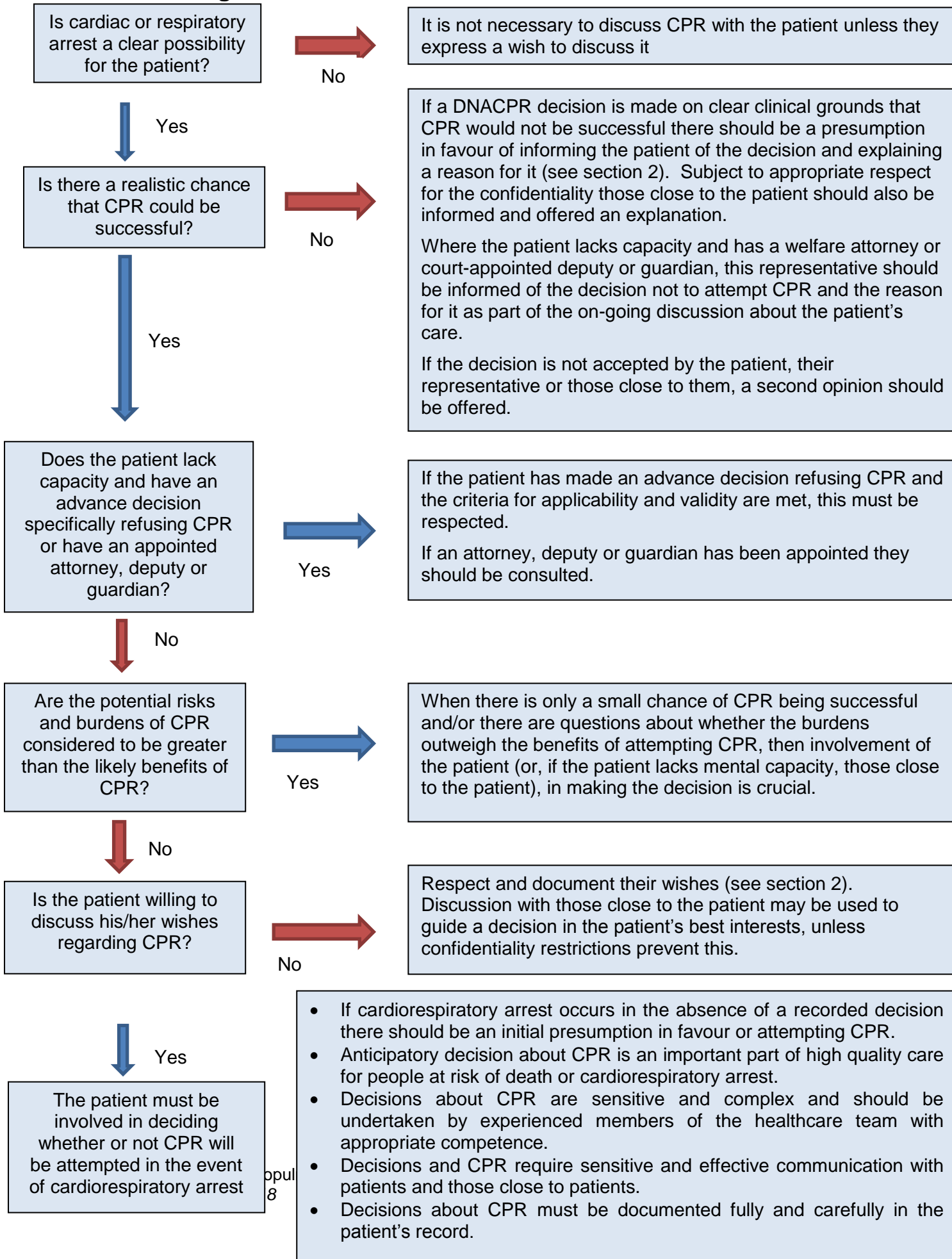
- 2.16 Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form.
- 2.17 A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include, but are not restricted to, choking, a displaced tracheal tube or a blocked tracheostomy tube.
- 2.18 A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not to attempt CPR rests with the healthcare professionals responsible for the patient's immediate care.
- 2.19 Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.
- 2.20 Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.
- 2.21 The original DNACPR form must accompany a patient when they move from one setting to another.

2.22 Organisations signed up to this policy.

Organisation	Committee signed up to Policy on behalf of Organisation
BMI – The Lincoln Hospital	
Butterfly Hospice Trust	
East Midlands Ambulance Service	
Lincolnshire Community Health Service	
Lincolnshire county Council (on behalf of commissioning nursing home care)	
Lincolnshire East CCG	
Lincolnshire Medical Committee	
Lincolnshire Nursing Home Association	
Lincolnshire Partnership NHS Foundation Trust	
Lincolnshire West CCG	
Marie Curie Cancer Care	
NSL Ambulance Transport Services	
South Lincolnshire CCG	
South West Lincolnshire CCG	
St Barnabas Hospice Lincolnshire	
United Lincolnshire Hospitals NHS Trust	

Section 3

Decision Making Framework



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

4. Legislation and Guidance

Legislation

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

The following sections of the Human Rights Act (1998) are relevant to this policy:

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14)
- In addition this policy takes heed of, and is compliant with, the Court of Appeal ruling on DNACPR decisions and the Human Rights Act (June 2014)

Guidance

Guidance has been developed by the Resuscitation Council (UK):

- Recommending standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
- Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (October 2007, updated October 2014)

Decisions relating to Cardiopulmonary Resuscitation are available at www.resus.org.uk/pages/decisionsrelatingtoCPR.pdf

5. Procedure

- 5.1 For the majority of people receiving care in a hospital or community setting, the likelihood of cardiopulmonary arrest is small; therefore, no discussion of such an event routinely occurs unless raised by the individual.
- 5.2 In the event of an unexpected cardiac arrest every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council (UK) unless a valid DNACPR decision or an ADRT is in place and made known.
- 5.3 In the event of a clinician finding a person dead and where there is no DNACPR decision or an ADRT to refuse CPR, the clinician must rapidly assess the case as to whether it is appropriate to commence CPR.

Providing the clinician has demonstrated a rational process in decision making, the employing organisation will support the member of staff if this decision is

challenged. Professional judgement must be exercised and documented as soon as practically possible after the event. Consideration of the following will help to form a decision:

- What is the likely expected outcome of undertaking CPR? *For example, it would be inappropriate to start CPR if it will not re-start the heart and maintain breathing.*
- What is the balance between the right to life and the right to be free from inhuman and degrading treating (Human Rights Act 1998)?

5.4 It is rarely appropriate to discuss DNACPR decisions in isolation from other aspects of end of life care. DNACPR is only one small aspect of advance care planning which can help patients achieve their wishes for their end of life care. The patient should be given as much information as they wish about their situation, including information about CPR in the context of their own illness and sensitive communication around dying and end of life issues.

5.5 Following transfer between healthcare settings, DNACPR decisions remain valid but should be verified as soon as possible by the clinician with overall responsibility for the person's care. The unified DNACPR form (Appendix 1) should be used and accepted by all providers across Lincolnshire. However, it is possible that a patient may have a DNACPR decision documented on a different form. For example, they may have been transferred from a different county, an old version of the form may have been used in error, or their DNACPR decision may have been documented in an Advance Decision to Refuse Treatment without an accompanying form. Unless there is a good reason to believe the DNACPR decision is not genuine or applicable, it should be accepted as valid until the decision is reviewed by the patient's responsible senior clinician. Similarly, a photocopy of a DNACPR form should be accepted unless there is evidence it should not be considered valid. However, if the original form is not present with the patient, a new form should be completed at the earliest opportunity.

6. Completing the DNACPR Form

These are the guidelines for completing the Unified DNACPR Form for use across all providers in Lincolnshire, section by section. There are brief guidance notes available on the back of the form.

Box 1 - Patient details

Enter the patient's full name, date of birth and NHS number. An addressograph label may be used providing it contains all three identifiers.

Box 2 - Date of DNACPR decision

Enter the date that the decision was made. A judgment then needs to be made whether the DNACPR decision will need to be reviewed. A fixed review date is not normally recommended, as this may lead to uncertainty about the validity of the form once the review date has passed, if a review does not take place.

The decision should be regarded as indefinite unless:

- A definite review date is specified. If a date is specified the form will be regarded as invalid after that date unless it has been reviewed.
- There are significant changes in the patient's condition. This will prompt a review of the decision with the patient.
- The patient's wishes change. This will also prompt a review of the decision with the patient.

Box 3 - Patients preferred place of care

Discussions with patients about CPR are best undertaken as part of a wider conversation about their understanding around their illness, their treatment and care options and preferences. This would usually include asking about their preferred place of care. This information can be documented in this section, and updated if it changes.

Box 4 - Reason for DNACPR decision

Tick one or more boxes to indicate the reason for the DNACPR decision, and provide further information to support the decision.

4 a) CPR is unlikely to be successful

State the underlying condition and reasons why CPR would be unlikely to succeed. Where a patient is likely to die naturally because of an irreversible condition, CPR would not be successful and should not be attempted. In these circumstances, it is a medical decision not to attempt CPR, and patients cannot insist on treatment that is clinically inappropriate. However, it should be discussed with the patient and their relatives or carers and the reasons for the decision explained.

4 b) Successful CPR is likely to result in a length and quality of life not in the best interests of the patient

State the reasons why CPR is not felt to be appropriate. Where there is only a small chance of success and the burdens of attempting CPR may outweigh the benefits, the involvement of the patient is crucial. When the patient has capacity their own views should be the primary guide in decision-making. If the patient lacks capacity, their relatives, carers, Power of Attorney or others should be involved to explore the patient's wishes, beliefs and values to help make a "best-interests" decision. It is important they understand they are not being asked to be the final decision-makers. In cases of doubt or disagreement a second opinion should be sought.

4c) Patient does not want to be resuscitated

State the evidence for coming to this conclusion. If a patient with capacity refuses CPR, or a patient without capacity has a valid and applicable advance decision to refuse treatment (ADRT) specifically refusing CPR, this must be respected.

Box 5 - Record of discussion

Tick the appropriate boxes and provide further information to identify the discussions that have taken place regarding this decision, and who else the information has been shared with. Discussions should be documented in more detail than this form will allow, so ensure all decisions and discussions have been fully documented in the patient's clinical notes.

5 a) Has the decision been discussed with the patient?

There should be clear, accurate and honest communication with the patient, providing information about the decision and checking their understanding of what has been explained. It would not be appropriate to decide to avoid a discussion with the patient on the basis that it might cause them distress, although a patient can decline to be involved in discussions they do not wish to take part in. However, it may be deemed inappropriate to involve a patient in a discussion around CPR if the clinician considers that to do so would be likely to cause the patient to suffer physical or psychological harm.

5 b) Has the decision been discussed with the relatives / carers / power of attorney or others?

There should also be clear, accurate and honest communication with those close to the patient (unless the patient has requested confidentiality). Where the patient lacks capacity, discussion with those close to them should be used to help guide a best-interests decision. If the patient has an attorney or court-appointed deputy, they should be consulted.

5 c) Who else has this decision been shared with?

Any decision about CPR should be communicated clearly to all those involved in the patient's care, particularly on transfer to a different healthcare setting. In order to facilitate these, the patient and where appropriate their carer should be advised by the person completing the form, that the form can be honoured outside of the care environment where it has been completed, but they must inform others that the order exists and ensuring it is available for review in an urgent/emergency situation. A copy of the form can be forwarded to relevant healthcare professionals, but the original must remain with the patient.

5d) Has a patient information leaflet been offered to the patient or family?

Organisations should ensure a relevant patient information leaflet is available for patients and those close to them. This leaflet should be offered as part of the discussion around the DNACPR decision, but should not be used as a substitute for a full verbal discussion.

Box 6 - Healthcare professional completing this DNACPR

The healthcare professional completing the form should fill in their details and sign the form. The decision must be discussed and agreed with the senior clinician responsible for the patient's care. This might be their GP, hospital consultant or out of hours practitioner depending on the setting.

The name of the responsible senior clinician the DNACPR was discussed with should be clearly documented and their agreement confirmed.

For patients who are being cared for within United Lincolnshire Hospitals NHS Trust, there is a requirement for the responsible consultant to review and endorse the form within 24 hours of the decision being implemented. They must countersign the form in the space provided. There is not a similar requirement for GPs given the logistical difficulties this might present for patients in the community, but where appropriate the GP may wish to countersign the form to further confirm their agreement with the decision.

7. Situations Where There is a Lack of Agreement

- 7.1 A person with mental capacity may refuse any treatment from a doctor or nurse even if that refusal results in death and any treatment carried out against their wishes is technically an assault. In these circumstances, Individuals should be encouraged to make an ADRT.
- 7.2 Should the person refuse CPR, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives, has taken place.
- 7.3 A verbal request to decline CPR is not legally binding; however it should not be ignored and does need to be taken into account when making a best interest decision. The verbal request needs to be documented by the person who it is directed to and any decision to take actions contrary to it must be robust, accounted for and documented clearly in the patient's notes.
- 7.4 Although individuals do not have a legal right to demand that doctors carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected wherever possible.
- 7.5 In the case of disagreement a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought from the organisations legal representatives.

8. Cancellation of DNACPR Decision

- 8.1 If the person's clinical condition changes, the decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form must be crossed through with two diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional, who will print their name and GMC number clearly underneath their signature for purposes of validation
- 8.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all relevant parties involved in the care of the patient.

9. Temporary Suspension of DNACPR Decision

- 9.1 In some circumstances there are reversible causes of a cardiorespiratory arrest. These are either pre-planned or acute and it may be appropriate for the DNACPR decision to be temporarily suspended under these circumstances.
- 9.2 Pre-planned: Some procedures could precipitate a cardiopulmonary arrest for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc.; under these circumstances the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people including the patient and/or carer, if appropriate, will need to take place.
- 9.3 Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation such as anaphylaxis or choking, CPR would be appropriate while the reversible cause is treated.
- 9.4 After the event, the DNACPR decision should be reviewed and discussed with the patient and reinstated where appropriate.

10. References

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NHS

Lincolnshire Health & Care Services, Working in Partnership

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over.

In the event of a cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR).
All other appropriate care and treatment will be provided.

<p>1. Patient Details (or affix addressograph label)</p> <p>Surname _____</p> <p>First Name(s) _____</p> <p>Date of Birth _____</p> <p>NHS Number _____</p>	<p>2. Date of DNACPR decision: _____</p> <p>Is a review date appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes state planned review date: _____</p> <p>Review Date _____ Name _____ Signature _____</p>
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3. Patients preferred place of care: _____

4. Reason for DNACPR decision (tick one or more boxes and provide further information below)

a) CPR is unlikely to be successful because: _____

b) Successful CPR is likely to result in a length and quality of life not in the best interest of the patient because: _____

c) Patient does not want to be resuscitated as evidenced by: (e.g. documented discussion or valid ADRT) _____

5. Record of discussion (tick one or more boxes and provide further information below)

a) Has the decision been discussed with the patient? Yes No
 If 'yes', record content of discussion. If 'no', state why not discussed.
 Note: It would not be appropriate to avoid a discussion with the patient on the basis that it might cause them distress.

b) Has the decision been discussed with the relatives / carers / Power of attorney or others? Yes No
 If 'yes', record name, relationship and content of discussion. If 'no', state why not discussed.

c) Have you discussed the safekeeping of this form with the patient/carer? Yes No Details: _____

d) Has a patient information leaflet been offered to the patient or family? Yes No
 If 'no', state the reason: _____

Ensure decisions and discussions have been documented in the patient's clinical notes.

6. Healthcare professional completing this DNACPR
 (The decision for the DNACPR must be discussed with the responsible senior clinician, e.g Hospital Consultant, GP, Out of Hours Practitioner)

Name _____ Signature _____

Position _____ GMC /NMC No. _____

Date _____ Time _____ Bleep/Contact No. _____

Name of responsible senior clinician the DNACPR was discussed with: _____

Signature of Consultant discussed with (ULHT only): _____ Date: _____ GMC No: _____

This original form remains the property of the patient. If they transfer to a different healthcare setting, the original MUST go with the patient. A black & white photocopy can be made to be retained in the medical records. If the DNACPR decision is cancelled, the form should be crossed through with 2 diagonal lines in black ball-point ink and the word "CANCELLED" written clearly between them, dated and signed by the healthcare professional, with their name and GMC/NMC number clearly identifiable.



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over.

In the event of a cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR).
All other appropriate care and treatment will be provided.

Guidance Notes

- This DNACPR form is intended to be used countywide across Lincolnshire by all Healthcare Providers.
- This form should be completed legibly in black ball-point ink, and used in accordance with the local resuscitation policy.
- A DNACPR decision only relates to cardiopulmonary resuscitation where the patient is in cardiopulmonary arrest, not to any other form of care or treatment. All discussions relating to this decision must be documented in the patient's clinical notes.
- This form remains the property of the patient, and it is transferrable to other healthcare settings. If the patient moves to a different location, the original copy of this form **MUST** go with the patient, but a black and white photocopy can be retained in the medical records. The clinical team responsible for the patient must ensure their professional colleagues receiving the patient are aware of the decision.

Box	Issue	Guidance
1	Patient details	Full name, Date of Birth and NHS Number will all be entered. An addressograph label may be used providing it contains all 3 identifiers.
2	Review date	A fixed review date is not normally recommended. The decision should be regarded as indefinite unless: <ul style="list-style-type: none"> • A definite review date is specified. If a date is specified the form should be regarded as invalid after that date unless it has been reviewed. • There are significant changes in the patient's condition. This should prompt a review of the decision with the patient. • The patient's wishes change. This should also prompt a review of the decision with the patient.
3	Patient's preferred place of care	Please enter the patient's preferred place of care and update it if this changes. Establishing this forms an important part of advance care planning.
4 a)	CPR is unlikely to be successful	State the underlying condition and reasons why CPR would be unlikely to succeed. Where a patient is likely to die naturally because of an irreversible condition, not to attempt CPR is a medical decision. Patients cannot insist on treatment that is clinically inappropriate. However, it should be discussed with the patient and their relatives or carers and the reasons for the decision explained.
4 b)	Successful CPR is likely to result in a length and quality of life not in the best interest of the patient	State the reasons why CPR is not felt to be appropriate. Where there is only a small chance of success and the burdens of attempting CPR may outweigh the benefits, the involvement of the patient is crucial. When the patient has capacity their own views should be the primary guide in decision-making. If the patient lacks capacity, their relatives, carers, Power of Attorney or others should be involved to explore the patient's wishes, beliefs and values to help make a "best-interests" decision. It is important they understand they are not being asked to be the final decision-makers. In cases of doubt or disagreement a second opinion will be sought.
4 c)	Patient does not want to be resuscitated	If a patient with capacity refuses CPR, or a patient without capacity has a valid and applicable advance decision to refuse treatment (ADRT) specifically refusing CPR, this must be respected.
5	Record of discussion	There should be clear, accurate and honest communication with the patient, and with those close to them (unless the patient has requested confidentiality). It would not be appropriate to decide to avoid a discussion with the patient on the basis that it might cause them distress, although a patient can decline to be involved in discussions they do not wish to take part in. Any decision about CPR should be communicated clearly to all those involved in the patient's care, particularly on transfer to a different healthcare setting. The conversation with the patient must include how they can ensure that this decision is communicated with carers and care professionals.
6	Healthcare professional completing this DNACPR	The healthcare professional completing this form must ensure they have discussed the decision with the responsible senior clinician, and documented that they are in agreement with it. At UHCT a consultant must sign the document within 24 hours of initiation, in line with the policy.