



A DNACPR decision is intended to prevent inappropriate attempts at CPR where it **clearly will not work or would not be wanted by a patient**. An inappropriate CPR attempt can cause significant harm and distress to a patient and their family as a death during, or just after a CPR attempt will be undignified and highly traumatic. A DNACPR decision **does not refer to any treatment other than a CPR attempt when a patient's pulse and breathing have stopped**. Any unexpected acute deterioration must be assessed and managed appropriately for that patient irrespective of a DNACPR decision, and so **a medical emergency/999 call may be appropriate for a patient with a DNACPR form in place**.

Clinical decisions – would CPR realistically work for your patient?

The role of the clinical team is to decide whether CPR would realistically have a medically successful outcome (sustainable breathing and circulation) – if it will not work, do not offer it. Such decisions cannot involve quality of life judgements. It may be helpful to consider whether the patient would be appropriate for care in a Critical Care or Intensive Care setting as this is the likely outcome of a “successful” prolonged CPR attempt. The overall responsibility for the clinical decision about CPR lies with the most senior clinician (doctor or nurse) who has clinical responsibility for the patient during that care period. However, agreement within the multi-disciplinary team and with the patient and their relevant others is the optimal situation.

There should be a presumption in favour of sensitively informing patients of a clinical DNACPR decision in the context of their goals of care and possible treatment options unless (i) it is judged that this conversation would cause the patient physical or psychological harm, (ii) the patient refuses discussion, or (iii) the patient lacks capacity to engage. Where harm would be caused this explanation must be documented along with a plan to review the patient's ability to have this conversation.



Patient decisions about whether CPR would be wanted

Where CPR could realistically achieve sustainable life, but the overall benefit for the patient is in question in terms of the length or quality of that life, then the patient's wishes **must be** given priority. Where a patient has capacity, clinicians cannot make a DNACPR decision based on overall benefit unless the patient makes it clear that they do not wish to engage in such a decision. It would then be reasonable to ask if there is anyone else who should be consulted.

Where a patient lacks capacity to make a decision about CPR

If a current and valid advance statement or directive exists, this should be respected. Where CPR could realistically achieve sustainable life, any legally appointed welfare attorney or guardian should be approached to be involved in the decision-making process. If no such person has been appointed then the clinical team should make a decision based on a judgement of overall benefit for the patient. Information should be sought from those who know the patient and have a view on the patient's goals, values and previously expressed wishes.

The role of the relatives / relevant others

Where a patient has capacity, their permission must be obtained before any discussion about care issues takes place. Relatives must never be given the impression that their wishes override those of the patient. Where the patient lacks capacity relatives/relevant others can give information about what they feel the patient's wishes and goals of care are, but not such that they feel burdened with this responsibility, unless their status as legally appointed welfare attorney or guardian has been established. **Subject to confidentiality restrictions those close to the patient who lacks capacity must be informed of any CPR decision without delay unless it would clearly not be practicable or appropriate to do so.**

Discharge to home or care home

It is the clinical team's responsibility to ensure that the patient and family are aware of the positive role of the DNACPR form at home in the context of the patient's goals of care. The family should know what to do and who to contact in the event of the patient's death or in the event of a sudden deterioration. Out of hours, the emergency care information such as DNACPR is communicated via the electronic Key Information Summary (KIS) and the GP must be given enough information to update it in time for the patient's discharge. Every effort must be made to make sure that the emergency services are not called inappropriately where a patient's death is expected, but there may be times when a 999 call is required for urgent assessment. If it is not felt appropriate or possible to have the DNACPR form at home with the patient everyone should be aware that paramedics and police may provide a full emergency response if called to attend.

Patient with a DNACPR form being transported by ambulance

Ambulance control must be informed of the existence of the DNACPR form at the time of booking an ambulance, and the crew should take the original form home with the patient, if he/she and their family is aware of it, and when not, they must understand its instruction prior to any transfer in case the patient dies on that journey.

Where no DNACPR decision has been made and a patient has a cardio-pulmonary arrest

The presumption is that staff should attempt CPR in this event, but where this is clearly inappropriate (eg a patient who is in the very final stages of a terminal illness where death is imminent and for whom CPR would clearly not work), it should not be attempted. Any healthcare professional who makes and clearly documents this considered decision must be supported by their colleagues, employers and professional bodies.

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).

