




**KEY POINTS – these points emphasise new and commonly misunderstood aspects of the DNACPR policy but should not be read in exclusion from the policy document.**

1. The aim of this policy is to prevent CPR being given when it is inappropriate, contraindicated and/or unwanted, which may cause significant distress to patients and families. A death managed with inappropriate CPR treatment will be undignified and highly traumatic. Such a death at home or in a care home is likely also to involve the Scottish Ambulance and even the police, which can add greatly to the distress for the families and be upsetting for all those involved.
2. When it is as certain as it can be that CPR will not be successful (in achieving **sustainable** life) healthcare professionals **should not offer it or attempt it as a treatment**. Making that complex clinical judgement is a core role of all experienced clinicians.
-  3. When it is clear in advance that CPR will not be successful there should be a **presumption in favour of informing patients, and those close to a patient who lacks capacity, of a DNACPR decision before it is documented**. This information should always be shared sensitively in the context of exploring their goals of care and wishes around realistic emergency treatment options.
4. DNACPR conversations and discussions should never be held in isolation but should usually be **the last part of an evolving conversation** that starts with a patient's understanding of their current condition and level of vulnerability. Exploration of the patient's goals of care and wishes for end of life care can allow a decision about CPR to be considered or shared sensitively and in context.
5. When CPR will not be successful and a DNACPR decision has been made and documented, the only justification for not sharing this information with a patient is:
  - a. The **patient lacks capacity to engage** with that conversation (information must be shared with the welfare attorney/guardian or relevant others **as soon as possible** where this is **practicable and appropriate**);
  - b. The **patient refuses to engage** with that conversation (ask if there is anyone that the patient would give the clinical team permission to talk with about important healthcare issues?);
  - c. It is judged that the conversation would cause the patient **physical or psychological harm**.

 Achieving a shared understanding of the patient's clinical condition and goals of care should be the aim of the conversation rather than simply to inform of a DNACPR decision. This is a complex conversation and will rarely be appropriate to have by telephone. However there may be some well-considered situations where this is clearly the only practicable and appropriate way to achieve such a shared understanding. Clinicians may find themselves in a situation in which they take a conscientious decision that it is not practicable or not appropriate to inform those close to the patient immediately or for the conversation to take place in person. For example, they may believe that contacting and informing them at a particular time will cause them to suffer harm.



6. Family/carers of a patient who has capacity should not be involved in CPR discussions without that patient's consent. However, involvement of those close to the patient should be encouraged. Consent to discuss the benefits of a DNACPR form with family/ carers may be implied if the patient agrees that significant aspects of care can be discussed with them.
7. When CPR might be successful in achieving **sustainable** life, seeking the views of the patient (with capacity to be involved in the decision) regarding overall benefit is of paramount importance as the quality of the sustainable life that might be achieved is going to form part of the overall benefit decision.
8. Where CPR might be successful but the patient lacks capacity discussion with the relevant others (welfare attorney / guardian, family or lay carers) must inform the CPR decision where possible. The question is what the patient would have wanted rather than what the family want. Family or lay carers should never feel they are responsible for the CPR decision as that responsibility rests with the clinical team.
9. The DNACPR form is not a legal document as such, it is simply an immediately recognisable record of a clinical decision that provides **guidance for healthcare professionals who do not know the patient** and who need to make a rapid decision about CPR in an emergency situation.
10. For an unexpected acute deterioration a DNACPR form should never be taken as an indication that an emergency response is not needed. The fact that a DNACPR decision has been made has no bearing on the emergency response for that patient unless the pulse and breathing have stopped.
11. In the absence of a DNACPR decision it is presumed that clinical staff will attempt CPR if appropriate where a patient's pulse and breathing have unexpectedly stopped.
12. Where a patient is imminently and irreversibly dying the team that knows the patient can make a decision not to initiate CPR when the patient's pulse and breathing stop even if no DNACPR form is in place. Any healthcare professional who makes and clearly documents a considered decision not to attempt CPR in this situation should be supported by their senior colleagues, employers and professional bodies.
13. All of the processes and discussions around any CPR decision must be clearly and robustly documented in the clinical notes.
14. Where a clinical team is as certain as it can be that CPR will not be successful **and** that the patient is irreversibly deteriorating, the DNACPR decision will remain appropriate until the patient's death and does not need reviewed. However, senior clinicians taking over clinical responsibility for the patient (transfer or discharge to a different team) should still review the decision and document that they are in agreement.



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