

Do not attempt cardiopulmonary resuscitation (DNACPR)

FAQs

About a DNACPR	
What is a DNACPR decision?	<ul style="list-style-type: none"> ▪ DNACPR stands for 'Do not attempt cardiopulmonary resuscitation'. It is sometimes called DNAR (do not attempt resuscitation) or DNR (do not resuscitate) but these all refer to the same thing. ▪ Cardiopulmonary resuscitation (CPR) is an emergency procedure for a person who is in cardiac arrest to restart their heart. ▪ A decision about cardiopulmonary resuscitation (CPR) is made and recorded in advance. This decision is recorded on a DNACPR form, which is designed to be easily recognised and verifiable, so professionals can make decisions quickly about how to treat people. ▪ The DNACPR form may be called a DNACPR order or notice or decision.
When is a DNACPR form used?	A DNACPR gives guidance (mostly to healthcare professionals) on the best action to take, or not take, if the person's heart or breathing stops.
Working with a DNACPR form	A DNACPR form needs to be kept safely by the person (or by someone who cares for them). It needs to be stored safely and easy to access in case it is needed.
Setting up a DNACPR	
Who authorises a DNACPR?	A DNACPR form is issued and signed by a doctor.
Who should be involved?	The person concerned should have all the information they need, in a way they can understand it and they can have family, friends or advocates involved if they choose.
With a DNACPR will people still get treatment?	Yes. All other care and treatment would continue, a DNACPR decision is only about CPR when a person stops breathing and/or when their heart stops beating.

<p>When should a DNACPR be reviewed?</p>	<p>A person can change their mind at any time and the healthcare team should talk to them and give any information needed to help make a decision.</p> <p>The healthcare team should continually review both the person's condition and any decisions about CPR.</p> <p>A registered manager should arrange for a new discussion about a DNACPR:</p> <ul style="list-style-type: none"> ▪ if the person or those close to them request it ▪ if there are changes in their clinical prognosis ▪ when the person moves between services. <p>In the case of acute illness and changes in clinical prognosis, there needs to be sufficient review to enable the person to change their mind about their decision.</p> <p>There could be fewer reviews for a person who is at the end of their life for a progressive, irreversible condition.</p>
<p>How is a DNACPR form is used in a hospital</p>	
<p>Going into hospital/emergency treatment.</p>	<p>The current and correct DNACPR form must go with the person if they're taken to hospital along with a hospital passport. Hospital passports tell hospital staff about the person's needs, such as communication methods and what's important to and for them in relation to their emotional and physical wellbeing.</p> <p>If a person with capacity decides to refuse treatment or they have made an Advance Statement refusing treatment, this must be respected and considered in relation to hospital admission or treatment.</p> <p>A DNACPR form tells healthcare professionals involved in that person's care that CPR shouldn't be attempted. These forms exist because without one the healthcare team will always attempt CPR.</p> <p>People with DNACPR forms should still receive the treatment they need for their condition and be comfortable and pain-free.</p>

<p>Who makes the ultimate decision about life saving treatment like CPR when a person is critically ill?</p>	<p>DNACPR forms are not legally binding, this means a hospital doctor can review the clinical viability of CPR, taking into account the person's wishes, to decide if DNACPR is still appropriate. The most senior healthcare professional responsible for the person's immediate care at the time, will make the ultimate decision about whether CPR is attempted.</p> <p>The professional responsible must make sure their decision promotes human dignity and upholds the person's rights according to the Human Rights Act 1998 (ie, the right to life (Article 2); the right to be free from inhuman or degrading treatment (Article 3); the right to respect for privacy and family life (Article 8); 17; the right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and the right to be free from discriminatory practice in respect of these rights (Article 14).)</p> <p>DNACPR decisions need to be made in response to an individual's circumstances, without subjective assumptions about their quality of life.</p>
<p>Reasonable adjustments and human rights</p>	<p>Hospitals and health and care settings must make reasonable adjustments (under the Equality Act 2010), to make sure people with protected characteristics have equal access to treatment and care. (People with protected characteristics includes people with a learning disability and/or autistic people).</p> <p>Reasonable adjustments mean things like considering the environment, such as removing physical barriers or providing a quiet space, as well as changes to the way things are done. It may mean meeting with hospital staff ahead of hospital admissions and allowing a family member or care worker to stay with the person if this helps reduce their concerns or anxiety and enables access to treatment.</p>
<p>What happens at a best interest meeting?</p>	<p>The meeting is about what is best for the person, taking account of their preferences, values, beliefs and feelings. It should involve people who know the person best, such as family, care workers, doctor or specialist nurses.</p> <p>A DNACPR decision maker will be the doctor or consultant responsible for the person's health care; they need to consider and take account of the person's wishes wherever possible.</p>

Advance Care Plan (ACP)	
What is an Advance Care Plan (ACP)?	An Advance Care Plan (ACP) offers people the opportunity to plan their future care and support, including medical treatment, while they have mental capacity to make these decisions. A DNACPR can be part of this.
Who would have an ACP?	Not everyone will want to make an ACP but it may be especially helpful for: <ul style="list-style-type: none"> ▪ people at risk of losing mental capacity - for example, through progressive illness ▪ people whose mental capacity varies at different times - for example, through mental illness.
Mental capacity	
What about mental capacity?	<p>The process of preparing advance care plans can only involve someone with capacity to decide. If a person lacks capacity, then a best interest meeting will be held to decide what is best for the person and this will involve an advocate.</p> <p>An advocate is a suitable representative. An advocate may be a family member or friend. An Independent Mental Capacity Advocate (IMCA) is a trained person appointed to advocate/act on a person's behalf in their best interest if they lack capacity to make certain decisions and do not have anyone they know to act in their best interests</p>
Care workers and general information	
What should care workers be aware of?	<ul style="list-style-type: none"> ▪ Care workers need to know who has a DNACPR form, and where it is kept. ▪ Care workers need be vigilant of a DNACPR being put in place by hospital staff without consultation with the person or people close to them (representatives) and should take action to raise this if it occurs. ▪ Care workers should not be asked by hospital staff to 'consent' to a DNACPR. If the person lacks capacity, the best interest process needs to be followed. ▪ Access to treatment must not discriminate and must be in relation to the person's individual circumstances. ▪ DNACPRs only apply to CPR (chest compressions) not to any other treatment. ▪ It is unacceptable for any DNACPR decisions to be made without proper conversations with the individual, or an appropriate representative, taking into account their wishes and needs.

	<ul style="list-style-type: none"> ▪ A blanket DNACPR is never appropriate. DNACPR decisions should not be applied to groups of people. ▪ Raise concerns with the doctor who signed the DNACPR form or, in an emergency, speak to medical team providing care and treatment. ▪ Raise concerns with your local Safeguarding Adults Board. ▪ Raise concerns with CQC www.cqc.org.uk/give-feedback-on-care
<p>What does best practice look like?</p>	<ul style="list-style-type: none"> ▪ As a care worker you should support people to think about their wishes and to help them communicate this to the doctor responsible for their healthcare. ▪ If someone you care for has a long-term condition or a terminal illness, then you or someone from the healthcare team should talk to them about what they can expect and what treatment options they have. If it's likely that they'll have a cardiopulmonary arrest, then planning what will happen if that situation arises should form part of this conversation, and be discussed with their healthcare professional who would be responsible for authorising a DNACPR decision. ▪ Be proactive with personalised end of life care planning, make sure the person is involved in the assessment of their needs, wishes and what is important now and for their future care needs. ▪ Be sensitive – some people may not want to talk about this or to have an advanced care plan in place. ▪ Be ready at any time to explain the purpose of advance care planning and discuss the advantages and challenges. ▪ Together with the person (and their carer or family if they wish), think about anything that could stop them being fully involved and how to make their involvement easier. ▪ Think about the person's understanding of illness, death and dying, their communication preferences and ways of processing information. ▪ Tailor information to reflect the person's thinking and learning style. Be mindful about the language and phrases used when discussing end of life. (For example, people with a learning disability or cognitive impairment may find the concept of death difficult to understand. Autistic people may find it hard to think about situations they have not yet experienced. Use simple, direct language and

avoid euphemisms that might be taken literally. I.e., don't explain death as going to a better place or going to sleep. (Ref Bereavement – a guide for professionals autism.org.uk). Use naturally occurring situations to gather people's views; for example, when other people or pets die or when watching this happen on TV.

- Offer to discuss advance care planning at a time that is right for them.
- Make sure you have up-to-date information about the person's medical condition and treatment options to help the process and involve relevant healthcare staff if needed.
- There must be comprehensive records of conversations with, and decisions agreed with, people,
- Make sure that other people involved in the person's care (for example family carers, day services etc.) know about their wishes and decisions that have been made. These must be properly communicated to others who need to know them.

Lead responsible body:

- Ensure your service has robust monitoring systems that check DNACPR notices are appropriate and act quickly if they are not.
- Ensure you have systems to make sure that people's DNACPRs are stored, reviewed and communicated properly.
- Make sure managers and care staff are empowered, through training and supervision, to challenge DNACPR decisions that do not uphold people's rights and dignity.
- The Resuscitation Council have developed a template as part of the advance care planning process, called Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). When done well, this is a good tool to help focus and capture conversations about people's end of life wishes, to be shared with medical teams in an emergency to inform them of DNACPR decisions.
- Reactive approaches, where you are acting without a grasp of the person's people's needs and wishes. This means there is a risk the person's wishes cannot be taken into account in the event CPR being needed.