DO NOT ATTEMPT RESUSCITATION (DNAR) POLICY

To be read in conjunction with the Resuscitation Policy

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<td>Senior Managers Operational Meeting</td>
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<td>Date Ratified:</td>
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<tr>
<td>Title of Originator/Author:</td>
<td>Medical Director</td>
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<td>Name of Responsible Committee/Group:</td>
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<td>Relevant Staff Group/s:</td>
<td>All Clinical and Social Care Staff</td>
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This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000
Amendments: Version 3 was a new integrated policy to apply to both mental health and social care directorates following the acquisition of Somerset Community Health, which also took into account the revised clinical governance structure.

The policy has subsequently been updated with minor amendments, including the addition of the following Appendices:
- Memorandum of Understanding between various organisations across Somerset regarding the shared use of DNAR forms
- Electronic Palliative Care Coordination System (EPACCS) user guide
- EPACCS Information form (contacts)
- EPACCS Changes/Additions form
- Clinical Audit Standards

Document objectives:
This document will set out when to avoid inappropriate resuscitation and ensure the needs and wishes of patients are met. To ensure all DNAR decisions are transparent and are suitable for the individual circumstances of the patients. That all decisions about DNAR are communicated to all relevant healthcare professionals and that the appropriate services are included for vulnerable patients and this is clearly documented on all the necessary documentation.

Intended recipients: All Clinical and Social Care Staff

Committee/Group Consulted: Resuscitation Group; Clinical Policy Review Group; Executive Team meeting

Monitoring arrangements and indicators: The Policy will be regularly reviewed and maintained by the Resuscitation Group. The Resuscitation Group is a subgroup of the Clinical Governance Group and reports regularly according to a specified annual timetable.

Training/resource implications: Mandatory training as specified in the Trust Mandatory Training Matrix

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<td>Contact for review</td>
<td>Senior Nurse for Clinical Practice</td>
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<td>Lead Director</td>
<td>Medical Director</td>
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## CONTRIBUTION LIST

Key individuals involved in developing the document

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation or Group</th>
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<tbody>
<tr>
<td>All Group Members</td>
<td>Resuscitation Group</td>
</tr>
<tr>
<td>Nina Vinall</td>
<td>Senior Nurse for Clinical Practice</td>
</tr>
<tr>
<td>Chris Mortimore</td>
<td>Medical Director at initial publication</td>
</tr>
<tr>
<td>Andrew Dayani</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Anita Turner</td>
<td>Cardiac Services Manager</td>
</tr>
<tr>
<td>Steve Grundy</td>
<td>Resuscitation Officer</td>
</tr>
<tr>
<td>Jess Henry</td>
<td>Learning And Development Manager</td>
</tr>
<tr>
<td>Bob Jones</td>
<td>Mental Health Legal Strategies Lead</td>
</tr>
<tr>
<td>Nick Woodhead</td>
<td>Mental Health Act Coordination Lead</td>
</tr>
<tr>
<td>All Group Members</td>
<td>Clinical Policy Review Group</td>
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<tr>
<td>Jean Glanville</td>
<td>Claims and Litigation Manager</td>
</tr>
<tr>
<td>Andrew Sinclair</td>
<td>Equality and Diversity Lead</td>
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1. INTRODUCTION

1.1 This policy identifies legal and ethical standards for decision making in relation to Do Not Attempt Resuscitation (DNAR) orders. **DNAR refers to Not for Cardio Pulmonary Resuscitation (CPR).** This policy is based on the guidelines produced by the British Medical Association, Royal College of Nursing and Resuscitation Council (UK). This Somerset Partnership NHS Foundation Trust Framework and policy should be used in conjunction with the framework for DNAR decisions (Appendix A), the Somerset Partnership NHS Foundation Trust DNAR form (Appendix B), the Patient Information Leaflet, Quick Start Guide for the Electronic Palliative Care Coordination System, User Information for the Somerset Care Coordination System, and Additions/Changes Form (Appendix C) and Instructions for Use of Emergency Tubes (Appendix D), which can all be found appended to this policy. The purpose of the policy is to provide guidance and clarification for all clinical and social care staff working within Somerset Partnership NHS Foundation Trust regarding the process of making DNAR decisions.

1.2 Cardio-pulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are inevitable as 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 cardio-pulmonary arrest represents the terminal event in their illness and for whom CPR is inappropriate. It is also essential to identify those patients who would not want CPR to be attempted in the event of an arrest and who competently refuse this treatment option. Some patients who have capacity may wish to make an Advance Decision (please see Consent and Capacity to Consent to Treatment Policy) about treatment (such as CPR) that they would not wish to receive in some future circumstances (see reference list). A valid Advance Decision must be respected as long as these decisions are informed, current and made without coercion from others. It is also vital to encourage the involvement of patients, the health care team and people close to the patient in decision-making, and to ensure the communication of decisions to all relevant health and social care staff, relatives and carers (see paragraphs 5.28 and 5.41 below).

1.3 Where patients are admitted to hospital acutely unwell or become medically unstable in their existing home or healthcare environment their resuscitation status should be considered and discussed with them as soon as is reasonably possible. When no explicit decision has been made about resuscitation before a cardio-pulmonary arrest, and the express wishes of the patient are unknown, it should be presumed that staff would attempt to resuscitate the patient. Although this should be the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of an illness.

1.4 Throughout this document the term “relevant others” is used to describe patient’s relatives, carers, representatives, advocates, and those who have
a Lasting Power of Attorney. Where a Lasting Power of Attorney (LPA) exists, and the patient lacks capacity, the LPA holder should be consulted on the treatment programme and whether CPR should be attempted and their view should be respected as if it were the incapacitated patient’s view (Mental Capacity Act, 2005). This policy addresses issues with regard to adult DNAR decision-making (Appendix A).

1.5 It is essential this policy is clearly explained in a timely manner to patients and their carers in a language and format which they can easily understand. This may necessitate the use of language support services. It is considered essential to keep patients and their carers informed. This information should be imparted in a culturally sensitive way taking into account the different spiritual and religious beliefs in the community of Somerset.

2. PURPOSE AND SCOPE

2.1 This policy applies to all clinical and social care staff employed by Somerset Partnership NHS Foundation Trust.

2.2 This document will set out when to avoid inappropriate resuscitation and ensure the needs and wishes of patients is met to ensure all DNAR decisions are transparent and are suitable for the individual circumstances of the patients. All decisions about DNAR will be communicated to all relevant health and social care staff, relatives and carers and will be clearly documented on all the necessary healthcare documentation as detailed within this policy.

2.3 The aims of this policy are as follows:

- to ensure patients receive appropriate and effective resuscitation when necessary and without delay
- to ensure patients are treated with dignity and their human rights are respected
- to ensure patients’ rights are respected
- to promote current practice based on British Medical Association, Royal College of Nursing and Resuscitation Council (UK) Guidelines
- to implement a consistent approach to DNAR decision making
- to provide support for clinical staff
- to provide written information for patients and relatives (Appendix C)
- to comply with Department of Health requirements.
- to satisfy legal and professional requirements
- to minimise clinical risk, litigation and material loss
- to ensure the DNAR procedures are monitored and audited.
3. DUTIES AND RESPONSIBILITIES

3.1 Duties in respect of the requirements of this document are as follows:

3.1.1 The Trust Board has a duty to care for patients receiving care and treatment from the Trust and has overall responsibility for procedural documents and delegates responsibility as appropriate.

3.1.2 The Lead Director is the Medical Director who has devolved responsibility for the implementation of this policy.

3.1.3 The Identified Lead (Author) is the Medical Director and he will be responsible for producing written drafts of the document and for consulting with others and amending the draft as appropriate.

3.1.4 Heads of Service/Senior Managers have responsibility for implementing this policy and for ensuring adherence to this policy.

3.1.5 Line managers are responsible for ensuring that relevant staff are conversant with this and related policies. Line managers are responsible for ensuring that staff attend mandatory training for resuscitation and to report concerns in relation to resuscitation to the Senior Nurse for Clinical Practice.

3.1.6 All Medical and inpatient nursing staff including temporary staff are individually responsible for their actions including complying with this and related policies.

3.1.7 The Clinical Effectiveness Team is responsible for undertaking clinical audits as scheduled within the clinical audit plan.

3.1.8 The Clinical and Social Care Effectiveness Group is responsible for the implementation of any clinical audit recommendations agreed by the Medical Audit Group.

3.1.9 The Clinical Governance Group is responsible for approving this policy and will ensure it is reviewed at least every three years or sooner in line with local and/or national requirements. The Group is responsible for the overall monitoring of the Clinical Audit plan.

3.1.10 The Head of Corporate Governance has responsibility for holding the central database of procedural documents including this policy and for providing quarterly reports to each Governance Group highlighting which policies are due for review. The Corporate Governance Team also has responsibility for dissemination of the final document and archiving old versions.
4. EXPLANATIONS OF TERMS USED

Cardio-Pulmonary Resuscitation: What it is and what it is not

4.1 CPR measures include external chest compression, artificial respiration and, if indicated, defibrillation. These measures are normally undertaken by local staff, and should lead to an emergency call and other active resuscitation measures including defibrillation. CPR commenced immediately and in full following an unexpected collapse if there is a realistic expectation of it being successful.

4.2 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, and treatment of choking. Comfort and treatment measures will be given after assessment, consultation with patient and relevant others, and on the basis of clinical need. DNAR applies only to CPR procedures. It should be made clear to the patient, people close to the patient and to the health care team that it does not imply “non-treatment” and that all other treatment and care appropriate for the patient will be considered and offered. To avoid confusion the expression “Do Not Attempt Resuscitation” should be used and included in the patient’s notes.

Resuscitation Status

4.3 The resuscitation status must be clearly documented for all patients. In community hospitals and other community services within the Community Health Services Directorate this will be clearly documented on the medications administration record (MAR or drug chart) on the back, clearly stating ‘For Resuscitation’ or ‘Do Not Attempt Resuscitation. Within the Mental Health and Social Care Directorate DNAR decisions will be recorded as a Rio Alert.

4.4 RiO – System used within the Trust to Record Electronic Patient Records.

All other explanations of terms used are included in the text of this policy and are not separately stated here.

5. STATEMENT OF POLICY AND GUIDANCE

Principles

5.1 This policy is based on the following principles:

Circumstances of cardio-pulmonary arrest

5.2 If the circumstances of a cardio-pulmonary arrest cannot be anticipated, it is not possible to make a DNAR decision that can have any validity in guiding the clinical team. In order to make an informed decision about the likely outcome of CPR it is essential to think through the likely
circumstance(s) in which it might happen for the patient. It is an unnecessary and cruel burden to ask patients or relevant others about CPR when it seems unlikely that circumstances would occur where the patient would require CPR. This should never prevent discussions about resuscitation issues with the patient if they wish.

**When CPR would fail**

5.3 In the situation where death is expected as an inevitable result of an underlying disease, and the clinical team as a whole is as certain as they can be that CPR would fail, resuscitation should not be attempted. It is an unnecessary and cruel burden to ask patients and relevant others to decide about CPR when it is not a treatment option. Although patients should not be offered CPR where it is clear it will not work, discussion about resuscitation issues should be encouraged as part of helping the patient and their family (with patient’s consent) to understand the severity of the patient’s condition unless it is clear that such a discussion would be unwelcome. Open and honest communication is essential in this situation. Where a medical DNAR decision has been made because CPR will not work for the patient it is the responsibility of the medical and nursing team to ensure that the patient and relevant others (with patient’s consent) have the opportunity to be made aware of the severity of the patient’s condition.

A DNAR decision is likely to be appropriate under the following circumstances:

- **Where attempting CPR will not restart the patient’s heart or breathing.** If the healthcare team is as certain as it can be that attempting CPR would not restart the patient’s heart and breathing, the patient cannot gain any clinical benefit from an attempt. Consensus within the team about likely clinical outcome should be the aim, and decision-making must be based on clinical assessment of the patient’s condition and up-to-date clinical guidelines.

- **Where there is no benefit in restarting the patient’s heart and breathing.** There is no benefit to be gained if only a very brief extension of life can be achieved and the patient’s co-morbidity is such that imminent death cannot be averted. Similarly there is no benefit to be gained by the patient if he or she will never have awareness or the ability to interact, and is therefore unable to experience benefit.

**Communication**

5.4 Throughout their care, the patient should be given as much information as they wish about their situation including information about resuscitation. Relevant others can be given such information if the patient with capacity agrees. Professionals should not unilaterally decide how much information the patient should receive; their task is to find out how much the patient wishes to know or can understand. If a patient does not have
the capacity to make this decision, then the clinical team must decide the best option taking into account the knowledge of relevant others about the patient’s previous wishes. Relevant others should never be placed in a position such that they feel they are making a DNAR decision (but should be consulted if there is a valid Lasting Power of Attorney in an adult lacking capacity as the decision of the LPA holder should be respected, unless it is thought not to be in the best interest of the patient). Their role is simply to provide information about the patient’s previously expressed wishes or what they believe the patient would wish in this situation.

5.4.1 Communicating DNAR Decisions. A sensitive discussion relating to DNAR decision making should be held at the earliest opportunity on admission with a competent patient who is at foreseeable risk of cardiopulmonary arrest or has a terminal illness. The Mental Health and Social Care Directorate Admission Checklist (RCPA Policy Appendix K) states that in Older People’s mental health wards there should be a discussion within 24 hours of admission when this is indicated and that this should include reference to the existence of any advance decisions. The standards for the Community Health Directorate are set out in the ‘Admission, Transfer and Discharge Policy’. An information leaflet for patients and relevant others is included in Appendix C for use under these circumstances. This leaflet provides an explanation of CPR, how decisions are made and patient and carer involvement in these decisions. Information should not be forced on unwilling recipients and if patients indicate they do not wish to discuss resuscitation this wish should be respected and any information leaflet removed. Any discussion or information should take account of the patient’s communication needs e.g. their first language or sensory impairment (please refer to the Professional Interpreters and Translation Services Policy).

5.4.2 Any decision related to CPR should be communicated to the patient and / or relevant others if appropriate. The patient will also be informed of how this decision will be communicated to the wider clinical team.

5.4.3 Where a DNAR decision has been made and there is limited discussion with patient because he or she has indicated a clear desire to avoid such a discussion, this must be documented in the patient’s notes. However all patients and / or relevant others if appropriate should be informed of the outcome and any DNAR decision that has been made including arrangements for communicating the decision to the wider clinical team and other healthcare agencies. Further advice on record keeping in relation to patients lacking capacity is given below (further detail can be found within the Consent and Capacity to Consent to Treatment Policy). Further advice in relation to transfer of original red bordered DNAR forms on discharge is also given below in 5.31 and 5.33

5.4.4 The patient’s known wishes and decisions relating to attempting CPR should be communicated between healthcare professionals when a patient is referred or discharged for example between primary and secondary care.
5.4.5 If patients are transferred from one Trust facility to another, the doctor assuming medical responsibility for the patient’s care should review existing DNAR orders.

5.4.6 A DNAR decision needs to be clearly communicated to ambulance personnel (see paragraphs 5.31 and 5.39 below).

**Responsibility for DNAR decisions**

5.5 Responsibility for making the DNAR decision lies with the most senior doctor who has medical responsibility for that patient. Discussions about resuscitation are sensitive and complex and should be undertaken by experienced medical or senior nursing staff (the latter will include community hospital sisters and community matrons in the Community Health Services Directorate and ward managers in the Mental Health and Social Care Directorate). Where this discussion is undertaken by a senior nurse any decision must also involve the doctor holding medical responsibility for the patient. The decision making process and the clinicians involved must be correctly recorded according to the procedures set out in 5.28 – 5.41. However, subject to this the ‘Do Not Attempt Cardiopulmonary Resuscitation’ Form (Appendix B) can be completed by a senior nurse. It is recommended that staff have formal communication skills training in preparation for this clinical responsibility. He/she should discuss the decision for an individual patient with other health care professionals involved. DNAR decisions should take account of advance decisions.

5.6 In discussions with relevant others, it should be made clear that their role is not to make decisions on behalf of the patient (unless the relevant other is a valid Lasting Power of Attorney holder), but to act as an advocate for the patient’s views and preferences.

**Quality of life**

5.7 This policy adopts the view that decisions should be based on immediate health needs, and not on a professional’s opinion on quality of life. This is primarily because opinions on quality of life made by health professionals are very subjective and often at variance with the views of the patient and relevant others. Where CPR may be medically successful, but result in a poor quality or length of life, the patient’s wishes about wanting or not wanting resuscitation to be attempted, are of paramount importance.

**Presumption to resuscitate**

5.8 When no explicit decision has been made about resuscitation before cardio-pulmonary arrest, and the express wishes of the patient are unknown, it should be presumed that staff would attempt to resuscitate the patient. Although this should be the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is clearly in
the terminal phase of an illness. **Medical or experienced nursing staff are therefore not obliged to initiate resuscitation measures for a patient where the death is clearly expected and due to an irreversible illness such that CPR would be unsuccessful and unquestionably inappropriate.**

5.9 In an emergency situation and in the absence of the patient's consultant/GP, the staff on duty should attempt CPR unless:
- the patient has refused CPR
- the patient is clearly in the terminal phase of illness.

5.10 Any DNAR decision must be made on current clinical information. This information should be reliable and up-to-date. A DNAR decision must be made on an individual basis. Standard rules or blanket policies are unlawful and cannot apply.

**Non-discrimination**

5.11 Any CPR decision must be tailored to the individual circumstances of the patient and made on current clinical information, which is reliable and up-to-date. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Standard rules and blanket policies that deny CPR to groups of patients are unlawful and unethical.

**Human Rights Act 1998**

5.12 Policies and individual decisions about CPR must comply with the Human Rights Act 1998. This Act incorporates the bulk of the rights set out in the European Convention of Human Rights into UK Law. In order to meet their obligations under the Act, health professionals must be able to show that their decisions are compatible with the human rights set out in the articles of the convention.

5.13 Provisions particularly relevant to decisions about attempting CPR include the right to life, to be free from inhuman or degrading treatment, to respect for privacy and family life, to freedom of expression, which includes the right to hold opinions and to receive information and to be free from discriminatory practice in respect of these rights.

**The Process of Making a DNAR Order (Appendix A)**

5.14 If it is not possible to anticipate circumstances where cardio-pulmonary arrest might happen there is no clinical DNAR decision to make. Do not initiate discussion about CPR with the patient or relevant others. The patient and relevant others should be informed that they can have a discussion, or receive information, about any aspect of their treatment. If the patient wishes, this may include information about CPR and its likely success in different circumstances. Continue to communicate progress to the patient and relevant others if the patient agrees. Reconsider whether a
DNAR decision is required only if circumstances change. In the event of an unexpected cardio-pulmonary arrest CPR should be carried out.

5.15 If the patient wishes to make an Advanced Statement that he/she would not wish to have CPR in the event of an unanticipated arrest this should be explored in a sensitive and realistic manner by an experienced member of the clinical team and any decision should be recorded as set out in 5.28 – 5.41 below.

5.16 **If the patient is dying as a result of an irreversible condition, CPR is unlikely to be successful. If the medical team is as certain as it can be that CPR would not have a medically successful outcome it is inappropriate to offer it as a treatment option.**

5.17 Good palliative care should be in place to ensure a comfortable and peaceful time for the patient, with support for the relevant others. Ensure that patient has and understands as much information about their condition as they want and need (the reasons why CPR will not be offered as a treatment option may be part of this information). See below for recording of DNAR decisions in the Mental Health and Social Care Directorate (5.28 – 5.31) and Community Health Services Directorate (5.32 – 5.41).

5.18 The Liverpool Care Pathway (LCP) of the Dying Patient is being used throughout the UK. The LCP provides a comprehensive template of evidence based multidisciplinary care for the last days of life. Goal 3 of the initial assessment of the LCP specifically prompts clinicians to consider and document the patient’s CPR status. Prior to being commenced on the LCP the clinical team agree that the patient is dying naturally. Therefore, patients who have been commenced on the LCP should not be for CPR. Please refer to the End of Life Care Policy.

5.19 Review regularly if the patient's condition changes. Review if medical responsibility for the patient changes (for example, patient is transferred to another speciality or is discharged home from hospital).

5.20 In the event of a patient undergoing acute treatment for example anaesthesia/surgery or any other interventional procedure, the DNAR decision may be temporarily overturned after discussion with the patient and senior clinician.

5.21 **If the patient is not dying as a result of an irreversible condition and if the team is as certain as it can be that CPR could have a medically successful outcome, the next decision is whether the patient has capacity to take part in this discussion and fully comprehend the implications of the decision.**
Valid advance decisions

5.22 CPR must not be attempted if it is contrary to the recorded sustained wishes of an adult who is mentally competent and is aware of the implications at the time of making that advance decision. An advance decision should be made in writing and it must be signed and witnessed. It must clearly state that it is to apply “even if life is at risk and death will predictably result”. If the service user does not wish to express their views in writing it should be explained to them that this, in effect, leaves the final decision with the most senior medical clinician involved. Where a valid advance decision to refuse CPR exists, the decision is binding regardless of the views of others. Further guidance is given in the ‘Consent and Capacity to Consent to Treatment’ Policy and in the Mental Capacity Act Code of Practice paragraphs 9.24 and 9.40 – 9.44.

Abnormal mental state

5.23 If a service user is expressing a wish not to be resuscitated there should always be a thorough assessment of mental state. In particular there should be assessment of suicidal thoughts or suicidal intent. Abnormal mental state is obviously an important factor in a psychiatric setting, which may adversely affect capacity to make decision.

5.24 Adults should be presumed to have capacity unless there is evidence to the contrary. If there is any doubt that the patient does not have capacity for example the patient has learning disabilities, is suffering from depression or is under the influence of others, then they would warrant a formal assessment of capacity. As assessment of capacity should relate to the specific decision the patient is being asked to make and their ability to fully comprehend their situation and the implications of their decision.

5.25 If the patient has capacity to make this decision:

- discuss the options with the patient unless they make it clear they do not wish to have this discussion
- continue to communicate progress to the patient and relevant others if the patient agrees

5.26 If the patient does not have capacity to make this decision:

- enquire about previous wishes from the relevant others to help the clinical team make the most appropriate decision
- continue to communicate progress to them

Adults who lack capacity

5.27 With regards to incapacitated adults, people close to the patient should be kept informed about the patient’s health and be involved in the decision making in order to reflect the patient’s views and preferences. Relatives
and others close to the patient should be assured that their views on what
the patient would want will be taken into account in decision making. If no
relatives are available to consult one should involve an Independent
Mental Capacity Advocate (IMCA). An advisory note from NHS Somerset
and Advocacy in Somerset (March 2010) concerning involvement of
IMCAs in DNAR decisions has however stated that there is no requirement
to instruct an IMCA in an emergency situation or if it is very unlikely that
CPR will be successful (i.e. if it would be futile); the decision must be
based on the physical condition of the patient and reasons for not referring
to the IMCA service should be recorded in the clinical notes. Where a valid
Lasting Power of Attorney (LPA) exists, the LPA holder should be
consulted on the treatment programme and whether CPR should be
attempted; their view should be respected as if it were the incapacitated
patient’s view (Mental Capacity Act, 2005). For more information refer to
the individual Directorate Trust Policies on consent and capacity to
consent to treatment, which apply to the relevant clinical area.

**Mental Health and Social Care Directorate Recording of DNAR
decisions (paragraphs 5.28 – 5.32 below)**

5.28 There should be routine consideration of DNAR issues on admission to
Mental Health and Social Care wards as set out in 5.5 and 5.14 - 5.21. Any
discussion with patients and relevant others including any decision
making process should be recorded in the progress notes (RiO).
Whenever appropriate the discussion should include an enquiry about
Advance Decisions. Any assessment of capacity should be recorded as
stated in 5.30 below. The consultant will not be available to review all
patients at the point of admission. Nevertheless the admitting doctor and
nurse should themselves jointly consider the issue on admission and make
a record of any decision in the patient’s care plan. Any DNAR decision
should be discussed at the time with the most senior doctor responsible for
the care of the patient (out of hours this will be the consultant / associate
specialist on call) and an entry made in care plan for a review within 72
hours by the consultant responsible for their ongoing care (see 5.29).
Any DNAR decision should also be recorded as a RiO alert.

5.29 All patients admitted to older people’s wards should have an intervention
in the care plan completed within 24 hours of admission relating to CPR. In
instances where the consultant has not had opportunity to review the
patient the care plan should include arrangements for this review to take
place. The review should take place within 72 hours and preferably sooner
if (a) the patient has refused resuscitation and / or (b) is clearly in the
terminal phase of an illness and / or (c) a DNAR decision has been made
in consultation with the consultant / associate specialist on call. A record of
the consultant review and the decision reached should be recorded in the
progress notes (and any assessment of capacity should be recorded as
stated in 5.30 below); the care plan should be amended and a RiO alert
should also be made if there is a DNAR decision.
5.30 **Recording DNAR Decisions.** A record should be made of assessment of capacity and of any discussions that have taken place with the patient and/or persons close to the patient, along with those with the wider healthcare team. This should be recorded within the RiO Consent and Capacity module. When a DNAR decision has been made and there is no discussion with the patient because he or she has indicated a clear desire to avoid such discussion, this must also be documented. Any DNAR decision and the reasons for it must be clearly entered in the patient’s notes and whenever possible the entry should be by the most senior medical member of the team (see 5.5 above). **The decision should be recorded as a RiO Alert to provide the most readily accessible documentation for all relevant health care professionals involved in the care of the patient.** To avoid confusion the expression “Do not Attempt Resuscitation” should be used to note a DNAR decision in all patient’s notes. In relation to all recording and communication of DNAR related decisions the usual rules of confidentiality apply. Each ward should have a system in place to ensure that DNAR decisions are handed over between nursing shifts so that appropriate action can be taken in an emergency situation. Resuscitation status should not be recorded on the ward white board because of the risk of misidentification of patients, for example if names are transcribed on the board.

5.31 In addition, in order to facilitate good communication between different agencies, a ‘Do Not Attempt Cardiopulmonary Resuscitation’ Form (Appendix B) should be completed and forwarded by fax to the South West Ambulance Service NHS Trust (SWAST - Fax Number: see Appendix B). A note should be made in the RiO Progress Notes that the form has been completed and a signed copy, endorsed by the doctor in charge of the patient, should be uploaded for incorporation into the document section of the patient RiO record under the Document Code ‘DNAR’. The original red border paper copy should accompany the patient on discharge to be stored in nursing notes in care homes or in the emergency information tube in the patient’s own home. As stated in 5.4.3 above the patient and / or relevant others should be informed of this process including arrangements for communication with other agencies. A copy should also be scanned and retained in the Rio record under the Document Code ‘DNAR’ – for this purpose the instruction on Appendix B ‘Do Not Photocopy’ can be ignored. *(Appendix D – provides an explanation on access to and use of emergency information tubes).*

5.32 To reduce the risk of unauthorised disclosure, the following steps should be taken when sending information by fax:

- Confirm that you have the correct fax number for the recipient.
- Confirm with the intended recipient that the receiving fax machine is located in a secure area or that the intended recipient is waiting by the fax machine to receive the transmission (confirmation has been provided by SWAST that the fax number on the DNAR form relates to a fax machine in a secure area). The telephone number for SWAST is 01202 851332.
• Trust approved standard fax cover sheets must be used with all fax transmissions. Cover sheets must not be used to transmit information on, separate sheets must be used.

• When a fax number is entered manually, the sender must visually check the recipient’s fax number against the cover sheet before starting transmission. Some machines require the number to be entered twice as an additional precaution.

• Telephone the intended recipient on the number stated above to confirm that they have received the transmission.

• Fax confirmation sheets must be checked as soon as possible after transmission to confirm that the receiving fax number and number of sheets transmitted are correct.

• Staff must not leave documents containing personal data unattended at fax machines.

• Those staff which receive faxes regularly should check the fax machines periodically for faxes.

• Any breech of faxed information must be reported on a Datix Untoward Event Report form. If the breech was made by another Trust or organisation then that Trust or organisation should be notified.

Community Health Services Directorate Recording of DNAR decisions (paragraphs 5.33 – 5.42 below)

5.33 Document all discussions in the patient’s notes detailing the circumstances that any decision relates to and who was involved in the decision making process

• complete DNAR form if appropriate
• review regularly and if circumstances change
• in the event of a cardio-pulmonary arrest, act according to the patient’s previous wishes (or if the patient does not have capacity, follow the decision made by the clinical team).

5.34 In addition to completion of resuscitation status on the MAR Chart (see 4.3 above), in the event of a DNAR decision the Somerset Partnership NHS Foundation Trust DNAR Form (Appendix B) should be completed and a signed copy, endorsed by the doctor in charge of the patient, should be forwarded by fax to the South West Ambulance Service NHS Trust (Fax number: see Appendix B). See 5.32 above for Information Governance advice in relation to sending information by fax. The original red bordered form should be kept in the front of the patient’s notes while they remain in hospital. The original red border paper copy should accompany the patient on discharge to be stored in nursing notes in care homes or in the emergency information tube in the patient’s own home. As stated in 5.4.3 above the patient and / or relevant others should be informed of this process including arrangements for communication with other agencies. A copy should also be retained in the patient’s notes; for this purpose the instruction on Appendix B ‘Do Not Photocopy’ can be
ignored. (Appendix D – provides an explanation on access to and use of emergency information tubes). The Memorandum of Understanding between healthcare organisations is included in Appendix E. This includes additional requirements for palliative care patients. A record of palliative care patient’s DNAR status should also be recorded, with the patient’s consent, on the Electronic Palliative Care Coordination System (EPACCS – End of Life Register [Adastra]). If the patient is unable to give consent a ‘best interest’ decision should be taken. Any clinician cancelling a DNAR order is responsible for updating SWAST and EPACCS (if a clinician is unable to update EPACCS they should contact the Somerset End of Life Care Coordination Centre on 01749 836550 during office hours).

5.35 Any review of the DNAR decision must be recorded on the form and rationale documented in the patient’s notes.

Additional information in relation to the Somerset Partnership NHS Foundation Trust DNAR Form (Appendix B) applying to both the Mental Health and Social Care and Community Health Services Directorates (paragraphs 5.36 – 5.40 below)

5.36 The patient’s GP or Out-of-Hours (OOH) service and the South West Ambulance Service NHS Trust should be informed whenever a DNAR order is made or a DNAR order is removed. The South West Ambulance Service (SWAST) places a flag for each patient at an address where a DNAR decision has been made and therefore both DNAR decisions and also reversal of decisions should be communicated to SWAST. If a paramedic attends they will be guided by the presence of a valid original DNAR form and are not likely to accept resuscitation status recorded solely on a medications administration record (MAR Chart) or as a RiO Alert.

5.37 Reversal of a DNAR order should be recorded on the form, it should be scored through with a permanent marker to indicate the order is now obsolete. In the Community Health Service Directorate this should then be filed in the back of the patient’s notes. In the Mental Health & Social Care Directorate where there are electronic notes any retained paper copy in an inpatient folder should be similarly filed after scoring through with a permanent marker. In the Community Health Services Directorate the resuscitation status should also be amended on the medications administration record (MAR Chart) and an entry made in the patient’s notes. In the Mental Health & Social care Directorate the RiO Alert should be removed and an entry made in the Progress Notes.

5.38 Where a patient with a DNAR form is being discharged home or is dying at home it is the medical and nursing team’s responsibility to ensure that the family are aware of its existence and know what to do in the event of the patient’s death.

5.39 The ambulance section of the DNAR form (Appendix B) should be completed for any patient being transported on a pre-planned journey by
the Ambulance Service. Ensure that ambulance control is aware of the existence of the DNAR order at the time of booking the ambulance.

5.40 In addition to informing the patient’s GP or Out-of-Hours (OOH) service and the South West Ambulance Service NHS Trust (see 5.31 and 5.34) the out of hours community nursing service should also be informed of the existence of the DNAR order when the patient is being cared for in the community, for example through the referral process on discharge from a community hospital.

**Reviewing the DNAR decision**

5.41 DNAR decisions must be reviewed regularly.

5.42 The frequency of the review will be determined by the health care professional in charge but a review should occur at least on admission and discharge from an inpatient ward (including transfers between wards where there is transfer of medical responsibility). Recording of reversal of a DNAR decision is set out in 5.37 above.

A system should be in place in each ward to ensure that regular review takes place. The frequency of review may be influenced by:

- changes in the patient’s condition
- changes in the patient’s wishes
- transfer from one facility to another
- changes in the consultant/GP in charge.

**The Difficulties of Deciding a DNAR Order**

5.43 Patients and relevant others can surprise us with their decisions:

5.44 Some will wish to receive resuscitation despite marked disability with an advanced or irreversible condition. These are people who wish to continue fighting and could not conceive of giving up the option of resuscitation. Where CPR might be successful, offering resuscitation to these patients is our acknowledgement of their desire to continue treatment and makes the bereavement of relevant others less complicated since all possible treatments, from their perspective were carried out.

5.45 Some will wish to refuse resuscitation despite an apparent good or reasonable quality of life. These are people who would not want to prolong their lives. Withholding resuscitation from these patients is our acknowledgement of their wish not to suffer unnecessarily and makes the bereavement of relevant others less complicated since they feel the patient had their wishes respected.
The Role of Relevant Others

5.46 If a patient has capacity (i.e. capable of understanding their situation and the implications of what is being discussed) his or her agreement must be sought before discussing resuscitation issues with the relevant others. Where a patient with capacity refuses to allow such information to be disclosed to relevant others, this refusal must be respected.

5.47 Relevant others often see themselves as natural decision-makers in this situation and may be surprised and/or distressed if they are not allowed to “protect” the patient from such sensitive exploration of these issues.

5.48 It is generally good practice to involve those closest to the patient in discussions about resuscitation decisions and patients should be encouraged to let staff know who they would like to be involved.

5.49 Patients should also be asked who they would like to be involved in such discussions if and when they no longer have capacity to do so themselves. A Lasting Power of Attorney (LPA) can be appointed under the Mental Capacity Act (2005) and the LPA holder(s) can make decisions for a patient who lacks capacity, when it is agreed to be in the patient’s best interests.

Medical Predication of the Outcome of Resuscitation

5.50 Unfortunately many patients have unrealistic expectations of the success of CPR and its consequences. Explanations of the probability of survival to discharge can significantly influence the resuscitation choices of older patients.

5.51 Large studies have shown that for in-hospital arrests the success rates as defined by discharge from hospital are in the order of 15% (38% immediate survival and 25% at 24 hours). The most successful resuscitation attempts are those which involve acute respiratory failure or the prompt treatment of ventricular arrhythmias although this has not been shown to alter the overall survival to discharge from hospital.

5.52 Medical predication of the outcome of resuscitation would be as realistic as possible and take into account the clinical condition of the patient, the likely cause of the anticipated arrest and also the environment within which the patient is being cared.

When Consensus Is Difficult To Achieve

5.53 Where the patient lacks capacity and there is no valid LPA covering life-sustaining treatment, the senior doctor responsible for the patient’s care has the authority to make the final decision, but it is wise to reach a consensus relevant others and other staff. The patient with capacity can
refuse information to be disclosed to relevant others and this refusal must be respected.

5.54 On occasions a clear decision is difficult. When one or two members of the team hold a minority view, the rest of the team should respect their view and be prepared to review the situation after a time agreed by the whole team.

5.55 Staff or relevant others with continuing concerns should approach the consultant and senior nurse for discussion.

5.56 Staff who continue to have concerns should approach their line manager. Staff and relevant others who still feel dissatisfied should contact their Head of Service. The Medical Director has responsibility for resuscitation within the Trust.

5.57 The courts may have to be approached for the final say. This is usually a last resort, although courts can be helpful in deciding complex cases.

**Key Points**

**Making a decision about resuscitation**

5.58 A decision about the appropriateness of CPR can only be made if the situation(s) where CPR might be required can be anticipated for the particular patient (*for instance, recent myocardial infarction, pneumonia, advanced cancer etc.*). If such a situation cannot be determined then there is no medical decision to make and there is no need to burden patients with resuscitation decisions.

**Medical decisions about DNAR**

5.59 The role of the medical team is to decide if CPR is likely to have a medically successful outcome. Such decisions do not involve quality of life judgements.

5.60 It may help in making a medical decision to decide whether the patient would be appropriate for Intensive Care (*likely outcome of a “successful” prolonged resuscitation)*.

5.61 The Consultant/GP is accountable for the final decision following a consensus with the patient, staff and relevant others.

5.62 It is not necessary to ask a patient who is following the Liverpool Care Pathway and/or receiving palliative care to decide about resuscitation if the clinical team has determined that CPR will not have a medically successful outcome.
5.63  This must never prevent continuing communication with the patient and relevant others about their illness, including information about CPR, unless it is clear this discussion is unwelcome

**Patient decisions about resuscitation issues**

5.64  Where CPR is likely to have a medically successful outcome consideration of a DNAR order for quality of life reasons **must** be discussed with the patient and their wishes must be given priority in this situation.

5.65  Doctors cannot make a DNAR decision for a patient who has capacity based on a quality of life judgement unless the patient specifically requests that they do this.

**The patient who has incapacity and is unable to make a decision about resuscitation**

5.66  Enquire about previous wishes from the relevant others to help the clinical team make the most appropriate decision.

5.67  Continue to communicate progress to them.

**The role of relevant others**

5.68  Where a patient has capacity their permission must be sought before any discussion takes place with the relevant others.

5.69  Relevant others should never be given the impression that their wishes override those of the patient. They can give information about the patient’s wishes but should not be burdened with the decision unless they are a registered LPA holder in which case they may have the authority to make decisions on behalf of an incapacitated patient.

**Patients with a DNAR order at home or being discharged home**

5.70  Unless the patient withholds disclosure to others, it is the medical and nursing team’s responsibility to ensure that the relevant others are aware of the existence of the DNAR form and know what to do in the event of the patient’s death.

5.71  The DNAR decision must be communicated to the GP on the discharge letter.

5.72  Any Community Health Services Directorate DNAR Form should be kept at home in the patient’s fridge within emergency information tube (Appendix D).

5.73  The GP and OOH service must be made aware of the existence of the DNAR order.
5.74 Every effort must be made to ensure the emergency services are not called inappropriately where a patient’s death is expected.

Patient with a DNAR order being transported by ambulance

5.75 The ambulance section of the DNAR form must be completed for any such patient being transported on a pre-planned journey by South West Ambulance Service NHS Trust.

5.76 Ambulance control must be informed of the existence of the DNAR order at the time of booking the ambulance.

Where no DNAR decision has been made and patient arrests

5.77 The presumption is that staff would attempt to resuscitate a patient in the event of a cardiopulmonary arrest. However, it is unlikely to be considered reasonable for medical or nursing staff to attempt to resuscitate a patient who is in the terminal phase of an illness.

5.78 NB: The presence or absence of a DNAR Form or DNAR RiO Alert may not override clinical judgement about what is in the patient’s best interests in any other emergency (for example, choking, seizure or anaphylaxis etc.)

Dissemination and Implementation

5.79 The Policy for Do Not Attempt Resuscitation will be disseminated to all areas once agreed by the Resuscitation Group and ratified by the Senior Managers Operational Group. It will be made available to staff via the intranet service.

Standards/ Key Performance Indicators

5.80 Somerset Partnership NHS Foundation Trust will ensure that the Resuscitation practice is evidenced based, reflecting current Resuscitation Council’s guidelines.

5.81 All Resuscitation incidents occurring within Somerset Partnership NHS Foundation Trust will be reported on Datix and a report received by the Resuscitation Group to ensure policy standards are adhered to, lessons can be learnt and any learning points disseminated.

6. EQUALITY IMPACT ASSESSMENT

6.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged
by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

7. MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 Overall monitoring will be by the Clinical Governance Group. The Clinical Governance Group will receive assurance from the Resuscitation Group in the form of a regular report that adequate controls are in place regarding high quality and safe resuscitation practice including those relating to DNAR decisions.

7.2 The responsibility for undertaking clinical audit is held by the Resuscitation Group. Clinical Audit Standards are set out in Appendix F. The Clinical Effectiveness team oversee the Trust Clinical Audit Plan and this is monitored through the Clinical & Social Care Effectiveness (CSCE) Group. The Resuscitation Group and / or the Medical Audit Group will sign off key recommendations from clinical audit reports and the CSCE Group will monitor implementation of these recommendations. The CSCE Group also provide a quarterly progress report to the Clinical Governance Group highlighting good practice, areas of concern, significant risks and lessons learned. Audit reports and lessons learned will be hyperlinked into the Trust newsletter to raise staff awareness and where appropriate influence future training.

8. COUNTER FRAUD

8.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

9. RELEVANT CARE QUALITY COMMISSION (CQC) REGULATIONS (2010)

The standards and outcomes which inform this procedural document are as follows:

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10. **REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS**


SIX LIVES: The Provision of Public Services to People with Learning Disabilities Parliamentary and Health Service Ombudsman. HC 203-1


ENGLISH EXECUTIVE HELATH DEPARTMENT


CROSS REFERENCE TO OTHER PROCEDURAL DOCUMENTS

Admission, Transfer and Discharge Policy
Consent and Capacity to Consent to Treatment Policy
Consent to Examination and Treatment Policy
End of Life Care Policy
NHS Protect Counter Fraud Policy
Physical Assessment & Examination of Service Users Guidelines
Physiological Observations Policy for Adult Inpatients
Professional Interpreters and Translation Services Policy
Record Keeping and Records Management Policy
Recovery Care Programme Approach (RCPA) Policy
Resuscitation Policy
Serious Incident Requiring Investigation Policy
Staff Mandatory Training Matrix (Training Needs Analysis)
Untoward Event Reporting Policy
Verification of Expected Death Policy by Registered Nurses

All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet (within Policies and Procedures).
11. APPENDICES

Appendix A: Framework for DNAR Decisions
Appendix B: Do Not Attempt Cardiopulmonary Resuscitation
Appendix C: Patient Information: Decisions Relating to Cardiopulmonary Resuscitation
Quick Start Guide for the Electronic Palliative Care Coordination System
User Information for the Somerset Care Coordination System
Additions/Changes Form
Appendix D: Instructions for Use of Emergency Tubes
Appendix E: Memorandum Of Understanding
Appendix F: Clinical Audit Standards
APPENDIX A

Somerset Partnership NHS Foundation Trust Framework for DNAR Decisions
(see policy document for full details)

Can a cardiac or respiratory arrest be anticipated?
For example:
• Progressive cardiac or Respiratory compromise.
• Previous life-threatening event or condition in which cardiac arrest is likely
• Patient dying from irreversible condition e.g. advanced cancer

Has the patient or relevant others voiced concerns during discussions with clinical staff regarding resuscitation in the event of unexpected cardiac arrest?

CPR should be carried out
• Do not burden the patient or relevant others with a CPR decision.
• Continue to communicate and assess any concerns of the patients and relevant others. This may involve discussion about CPR and its outcome.
• Review only when circumstances change.
• In the event of cardio-pulmonary arrest, carry out CPR.

NO

NO

YES

SEEK SENIOR ADVICE

Are you as certain as you can be that CPR could have a medically successful outcome

YES

Are you as certain as you can be that CPR could NOT have a medically successful outcome?

YES

Advanced Decision on CPR is possible
• Sensitive exploration of the patient’s wishes regarding resuscitation should be undertaken by the most experienced staff available.
• If the patient has capacity to make this decision, discuss options of CPR and DNAR with patient. Involve relevant others if appropriate (with patient’s permission).
• If the patients does not have capacity to understand the implications of this discussion, the medical team should make this decision based on available information regarding patient’s previous wishes (from relevant others, other healthcare professionals or members of the multidisciplinary team). Relevant others should never be asked to make the decision unless there is a valid Lasting Power of Attorney for the patient.
• Document the decision and any discussion around that process.
• Continue to communicate and assess any concerns of the patient and relevant others.
• Ongoing review to assess any change in circumstances
• In the event of a cardio-pulmonary arrest, act in accordance with the documented decision.

NO

CPR inappropriate
• As CPR would not be successful it cannot be offered as a treatment option. A DNAR decision should be documented and communicated to those involved in the patient’s care according to the procedures set out in the DNAR Policy.
• Continue to communicate and assess any concerns of the patients and relevant others (which should include discussion about why CPR is inappropriate).
• Allow natural death with good palliative care and support patients and relevant others.
• Document decision and review if the patient’s situation changes.
• Ongoing review to assess any change in circumstances.
Medical decisions about DNAR

- The role of the medical team is to decide if CPR is likely to have medically successful outcome. Such decisions do not involve quality of life judgements.
- It may help in making a medical decision to decide whether the patient would be appropriate for Intensive Care (likely outcome of a “successful” prolonged resuscitation).
- The consultant/GP responsible for the patient’s care has the authority to make the final decision, but it is wise to reach a consensus with the patient, staff, relatives and/or relevant others.
- It is vital to continue to communicate with the patient and relevant others about their illness, including information about CPR if they wish.

Patient decisions about resuscitation issues

- Where CPR is likely to have a medically successful outcome, consideration of a DNAR order for quality of life reasons must be discussed with the patient, and their wishes must be given priority in this situation.
- Doctors cannot make a DNAR decision for a patient with capacity based on a quality of life judgement unless the patient specifically requests that they do this.

The Patient who has incapacity and is unable to make a decision about resuscitation

- Enquire about previous wishes from relevant others to help the clinical team make the most appropriate decision.
- Adults who lack capacity. With regards to incapacitated adults, people close to the patient should be kept informed about the patient’s health and be involved in the decision making in order to reflect the patient’s views and preferences. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision making. If no relatives are available to consult one should involve an Independent Mental Capacity Advocate (IMCA). An advisory note from NHS Somerset and Advocacy in Somerset concerning involvement of IMCAs in DNAR decisions has however stated that there is no requirement to instruct an IMCA in an emergency situation or if it is very unlikely that CPR will be successful (i.e. if it would be futile); the decision must be based on the physical condition of the patient and reasons for not referring to the IMCA service should be recorded in the clinical notes. Where a valid Lasting Power of Attorney (LPA) exists, the LPA holder should be consulted on the treatment programme and whether CPR should be attempted; their view should be respected as if it were the incapacitated patient’s view (Mental Capacity Act, 2005). For more information refer to the Trust Policy ‘Consent and Capacity to Consent to Treatment’.

The role of the relatives/relevant others

- The permission of a patient with capacity must be sought before any discussion takes place with the relevant others.
- Relatives should never be given the impression that their wishes override those of the patient. They can give information about the patient’s wishes but should not be burdened with the decision unless they are a registered LPA holder in which case they may have the authority to make decisions on behalf of an incapacitated patient.

Patients with a DNAR order at home or being discharged home
• It is the medical and nursing team’s responsibility to ensure that the relevant others are aware of the existence of the DNAR form and know what to do in the event of a patient’s death.
• Any Community Health Services Directorate DNAR form should be stored in an emergency information tube in the patient’s fridge. Stickers should be used to indicate the use of the emergency information tube. All relevant healthcare professionals should be informed of the existence of the DNAR form. Relevant information may be available on the Emergency Care summary.
• The GP and OOH Service must be made aware of the existence of any DNAR decision. Every effort must be made to ensure the emergency services are not called inappropriately where a patient’s death is expected.

Patient with a DNAR order being transported by ambulance on a pre-planned journey
• The ambulance section of the DNAR form must be completed for any such patient being transported by the English Ambulance Service.
• Ambulance control must be informed of the existence of the DNAR order at the time of booking the ambulance.

Where no DNAR decision has been made and patient arrests
• The presumption is that staff would attempt to resuscitate a patient in the event of a cardio-pulmonary arrest. However, it is unlikely to be considered reasonable for medical and experienced nursing staff to attempt to resuscitate a patient who is in the terminal phase of an illness.

The presence or absence of a DNAR form relates only to the provision of CPR and may not override clinical judgement about what is in the patient’s best interest in an emergency (e.g. choking, seizure or anaphylaxis etc.). CPR measures do not include analgesia, antibiotics, investigation or treatment of a reversible condition, feeding or hydration.
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

Name: __________________________ DOB: __________
Address: ___________________________________________
NHS or Hospital Number: ___________________________

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the patient have capacity to make and communicate decisions about CPR?
   - If “YES” go to box 2
   - If “NO”, have you seen a valid advance decision refusing CPR which is relevant to the current condition?  If “YES” go to box 6
   - If “NO”, has the patient appointed a Welfare Attorney to make decisions on their behalf?
     - If “YES” they must be consulted.
     - All other decisions must be made in the patient’s best interests and comply with current law. Go to box 2

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:

3. Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4. Summary of communication with patient’s relatives or relevant others:

5. Names of members of multidisciplinary team contributing to this decision:

6. Healthcare professional completing this DNAR order and forwarded to Ambulance Trust:
   - Name (Print) ____________________________ Designation ____________________________
   - Signature ____________________________ Date __________ Time __________

7. GP Name: ____________________________ Surgery: ____________________________ Tel No: ____________________________

8. Review and endorsement by most senior health professional GP or medic:
   - Signature ____________________________ Name ____________________________ Date __________
   - Review date (if appropriate)
   - Signature ____________________________ Name ____________________________ Date __________
   - Signature ____________________________ Name ____________________________ Date __________

This form should be completed legibly in black ball point ink

APPENDIX B
All sections should be completed

- The patient’s full name, date of birth and address should be written clearly
- The date of writing the order should be entered
- This order will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home
- If the decision is cancelled, the form should be crossed through with two diagonal lines in black ballpoint ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the order.

1 Capacity/ advance decisions
Record the assessment of capacity in the clinical notes. Ensure that any advance decision refusing CPR is valid (must be written, signed and witnessed, and must include a statement that the advance decision is to apply, even if life is at risk), and is applicable in the patient’s current circumstances. 16-17 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.

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests
Be as specific as possible.

3 Summary of communication with patient (or welfare attorney if appointed and if patient lacks capacity)
State clearly what was discussed and agreed. If this decision was not discussed with the patient, state the reason why this was inappropriate. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney with authority to make decisions about life-sustaining treatment on their behalf, that person must be consulted if the patient lacks capacity.

4 Summary of communication with patient’s relatives or friends
If the patient does not have capacity, and if cardio respiratory arrest is foreseen and CPR has a realistic prospect of success, their relatives or friends must be consulted to ascertain the patient’s relevant wishes, feelings, beliefs and values. This information must be considered when making the best interests decision regarding CPR. If CPR has no realistic prospect of success, consider explaining to relatives and friends that it will not be attempted.

State the names and relationships of relatives or friends of other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5 Members of multidisciplinary team
State names and positions. Ensure that the DNAR order has been communicated to all relevant members of the healthcare team.

6 Healthcare professional (GP/medic) completing this DNAR order
This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7 Endorsement/ review ...
The decision must be endorsed by the most senior healthcare professional, for example, GP or medic responsible for the patient’s care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.
Decisions relating to Resuscitation
This booklet explains

- what cardiopulmonary resuscitation (CPR) is
- how you will know whether it is relevant to you, and
- how decisions about it are made

It is a general leaflet for all patients but it may also be useful to your relatives, friends and carers. This leaflet may not answer all your questions about CPR, but it should help you to think about the issue. If you have any other questions, please talk to one of the health professionals (doctors, nurses and others) caring for you.

What is CPR?

Cardiopulmonary arrest means that a person’s heart and breathing stop. When this happens, it is sometimes possible to restart their heart and breathing with emergency treatment called CPR.

CPR might include:

- repeatedly pushing down very firmly on the chest;
- using electric shocks to try to restart the heart;
- mouth-to-mouth breathing; and
- inflating the lungs through a mask over the nose and mouth or tube inserted into the windpipe

Is CPR tried on everybody whose heart and breathing stop?

When the heart and breathing stop unexpectedly, for example if a person has a serious injury or heart attack, the healthcare team will try CPR if it might help. A person’s heart and breathing also stop working as part of the natural and expected process of dying. In these cases, restarting the heart and breathing may do more harm than good by prolonging the pain or suffering of someone who is soon to die naturally.

Do people get back to normal after CPR?

Each person is different. A few patients make a full recovery, some recover but have health problems and, unfortunately, most attempts at CPR are unsuccessful despite the best effort of everyone concerned.

How and whether a patient returns to normal depends on why their heart and breathing stopped working and the patient’s general health. It also depends on how quickly the heart and breathing can be restarted. Patients who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some patients never get back the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some have brain damage or go into a coma. Patients with many medical problems are less likely to make a full recovery. The techniques used to restart the heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs.
Am I likely to have a cardiopulmonary arrest?

The health professionals caring for you are the best people to discuss the likelihood of you having a cardiopulmonary arrest. People with the same symptoms do not necessarily have the same disease and people respond to illnesses differently. It is normal for health professionals and patients to plan what will happen in case of cardiopulmonary arrest. Somebody from the healthcare team caring for you, probably the doctor in charge, will talk to you about:

- your illness
- what you can expect to happen, and
- what can be done to help you

What is the chance of CPR reviving me?

The chance of CPR reviving you if you have a cardiopulmonary arrest will depend on:

- why your heart and breathing have stopped
- any illnesses or medical problems you have (or have had in the past), and
- the overall condition of your health

Attempted CPR is successful in restarting the heart and breathing in about four out of ten patients. On average, two out of ten patients survive long enough to leave hospital. The figures are much lower for patients with serious underlying conditions. It is important to remember that this only gives a general picture and not a definite picture of what you can expect. Everybody is different and the healthcare team will explain what CPR could do for you.

Does it matter how old I am or that I have a disability?

No. What is important is:

- your state of health
- your wishes
- the likelihood of the healthcare team being able to achieve what you want

Your age alone does not affect the decision, nor does the fact that you have a disability.

Who will decide about CPR?

You and your doctor will decide whether CPR should be attempted if you have a cardiopulmonary arrest. The healthcare team looking after you will look at the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long.

It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy. Sometimes, however, restarting people’s heart and breathing leaves them with a severe disability or only prolongs suffering. Prolonging life in these circumstances is not usually beneficial. Your wishes are very important in deciding whether resuscitation can benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in discussions. In most cases, where there has been good communication, doctors and their patients agree about treatment.
What if I don’t want to decide?

You don’t have to talk about CPR if you don’t want to, or you can delay this discussion if you feel you are being asked to decide too much, too quickly. Your family, close friends and carers might be able to help you make a decision you are comfortable with. If you don’t decide, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you’ve said.

If you are under 18, your parents can decide for you.

How can I make sure that nobody tries to resuscitate me?

I know that I don’t want anyone to try to resuscitate me. How can I make sure they don’t?

If you don’t want CPR, you can refuse it and the healthcare team must follow your wishes. You can make a living will (also called an ‘advance decision’) to put your wishes in writing. Discuss with your nurse or doctor for more information. If you have a living will, you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked.

If there are people you do (or do not) want to be asked about your care, you should let the healthcare team know.

If it is decided that CPR won’t be attempted, what then?

The healthcare team will continue to give you the best possible care. The doctor in charge of your care will make sure that you, the healthcare team, and the friends and family that you want involved in the decision, know and understand the decision, unless you don’t want to talk about it. There will be a note in your health records that you are ‘not for cardiopulmonary resuscitation’. This is sometimes called a ‘do-not-attempt-resuscitation’ or DNAR decision.

What about other treatment?

A DNAR order is about CPR only and you will receive all the other treatment you need.

What if my doctor says that CPR won’t work?

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there was any real possibility of it being successful. If there is doubt whether CPR might work for you, the healthcare team will arrange a second medical opinion if you would like one.

If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion about whether these chances are worth taking is very important. The healthcare team must listen to your opinions and to the people close to you if you want them involved in the discussion.
What if my situation changes?

The healthcare team will review decisions about CPR regularly if your wishes or condition change.

What if I change my mind?

You can change your mind at any time. Please talk about it to any of the healthcare team caring for you.

Can I see what’s written about me?

Yes, you can see what’s written about you. The healthcare team will make a note of what you say about CPR and of any decisions that are made. You can ask the healthcare team to show you your records and, if there is anything in them that you do not understand, they will explain it to you. You also have a legal right to see and have copies of your records.

Who else can I talk to about this?

- counsellors
- spiritual carers (such as a chaplain)
- Independent advocacy services
- Patient support groups

If you feel that you have not had the chance to have a proper discussion with the healthcare team, or you are not happy with the discussions you have had, please contact the Patient Advice and Liaison Service (PALS) on 01278 432022. They can help you or the people close to you and deal with your suggestions, worries or concerns.

If you would like to contact our Patient Advice and Liaison Service (PALS) please telephone 01278 432022 or email pals@sompar.nhs.uk

This leaflet is available in other formats, including easy read summary versions and other languages upon request. If this would be helpful to you, please speak to a member of staff.

Date Issued: January 2014
Review Date: December 2016
Author: Senior Nurse for Clinical Practice
Ref: CS CPR 001

Headquarters:
Somerset Partnership NHS Foundation Trust
2nd Floor, Mallard Court, Express Park,
Bristol Road, Bridgwater TA6 4RN

Tel: 01278 432 000 Fax: 01278 432 099
Email: foundationtrust@sompar.nhs.uk
Web: www.sompar.nhs.uk

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How Do I …
Quick Start Guide for the
Electronic Palliative Care Coordination System

Log onto System
Web address: https://eol.swast.nhs.uk/eol/login.aspx
Enter username and password and change password as requested the first time you log in.

Add patient to System
• From home page, select EOL - Note Edit from menu.
• Patients currently on the System are shown here. Check patient is not already on System.
• Select Add New Note.
• Search for patient from database – if on database, select Create Note located before patient name.
• Under Note Settings tick box, Exclude this patient from the patient experience questionnaire?
• If End of Life Care Register (Somerset) template is not displayed, select from drop down list.
• Select Yes to Has patient given consent for information sharing question.
• Complete the Core Information, Advance Care Planning, End of Life and Contacts tabs.
• Enter notes. It is important to start each note with the date, e.g. 09/06/10, enter the note detail, then complete with your name and role at the end.
• When all information has been added, select Add to save. Patient will appear on the Register list.

View or Edit an Existing Entry
From the System, select patient by clicking on Edit on the left hand side of the patient’s name. Edit details if required and select Add to save changes. Select Cancel if no changes have been made.

Discharge a Patient
• From the System, select patient by clicking Edit on the left hand side of the patient’s name.
• Under Note Settings, tick box to mark this patient as hidden.
• In End of Life tab, select Discharge in Reason for Patient Leaving Service and enter Date of Discharge.
• Select Update to save changes.

Decease a Patient
• From the System, select patient by clicking Edit on the left hand side of the patient’s name.
• Under Note Settings, tick box to mark this patient as hidden.
• In End of Life tab, select location of Actual Place of Death and complete Reason for Variance if applicable. Select Died in Reason for Patient Leaving Service and enter Date of Death.
• Select Update to save changes.

Change Patient’s GP – contact End of Life Care Co-ordination Centre
• From the System, select patient by clicking Edit on the left hand side of the patient’s name.
• Under Patient Demographics, delete practice information under Surgery. Enter new surgery name and pick from list that is displayed.
• Select GP from drop down list next to Doctor.
• Select Update to save changes.
User Information for the
Electronic Palliative Care Coordination System

Access

In order to access the System you will need a user account. Click on the link below to access the user account form.


A line manager will need to approve your user account application.

SOMERSET HEALTH INFORMATICS administer the user accounts and will assist with any technical problems.

Contact Details: Phone: 01823 287728 Email servicedesk@SomersetHIS.nhs.uk

Useful Contact Details

End of Life Discharge In-reach Nurses

Musgrove Park Hospital Phone: 07812 203 298 Yeovil District Hospital Phone: 07768 466637

Somerset End of Life Care Coordination Centre

Phone - 01749 836550 Fax – 01749 836528 Email: endoflifecare@sompar.nhs.uk

(Monday to Friday 8am to 6pm and Saturday/Sunday 10am to 3pm)

Local Information Website: www.nssomersetendolifecare.nhs.uk


Dr Chris Absolon, GP Palliative Care Lead – 01935 385263

Julie Brooks, Project Manager – 01935 384099
# ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM
## ADDITIONS/CHANGES FORM

### Details of Person Completing Form

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block Capitals</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>When form completed</td>
<td></td>
</tr>
</tbody>
</table>

### Consent

<table>
<thead>
<tr>
<th>Has patient given consent for information sharing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes [ ] No [ ] Clinician Decision [ ]</td>
</tr>
</tbody>
</table>

If Clinician Decision give reason

### Patient Demographics

<table>
<thead>
<tr>
<th>Forename</th>
<th>Surname</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Gender F [ ] M [ ]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Registered GP</th>
<th>Patient Phone No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NHS Number</th>
<th>Patient Mobile No</th>
</tr>
</thead>
</table>

### Contacts

<table>
<thead>
<tr>
<th>Key Worker Name</th>
<th>Associate Key Worker Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobile Number</th>
<th>Mobile Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key Worker Discipline</th>
<th>Associate Key Worker Discipline</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Carer Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Carer Contact Details</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Next of Kin Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Next of Kin Contact Details</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Known to Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes [ ] No [ ] Unknown [ ]</td>
</tr>
</tbody>
</table>

### Hospice Details

<table>
<thead>
<tr>
<th>Dorothy House Hospice – 01225 722999</th>
<th>St Margaret’s Hospice – 0845 070 8910</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weston Hospicecare – 01934 423912</td>
<td></td>
</tr>
</tbody>
</table>
### Core Information

<table>
<thead>
<tr>
<th>Red/Amber/Green Status</th>
<th>Red</th>
<th>Amber</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose either Red/Amber/Green)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

#### Red
- Patient’s condition rapidly changing/deteriorating
- There is a social crisis (carer breakdown)
- Patient is in the dying phase

#### Amber
- Patient’s needs changing/condition deteriorating
- Social situation has potential to breakdown
- Discharged from alternative care within 2 weeks
- Patient lives alone

#### Green
- Patient has palliative care needs, but physical and social situation is stable

## Main Diagnosis

<table>
<thead>
<tr>
<th>Co-existing Disease/Complications</th>
<th>□</th>
<th>□</th>
<th>□</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is patient aware of diagnosis?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does Patient live alone?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Is Anticipatory prescribing medication with patient?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If a syringe driver available with patient?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

## Advance Care Planning

<table>
<thead>
<tr>
<th>Has resuscitation been discussed with patient?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has resuscitation been discussed with family?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Resuscitation Status</td>
<td>For Resuscitation</td>
<td>Do Not Attempt Resuscitation</td>
<td></td>
</tr>
<tr>
<td>Has a Do Not Attempt Resuscitation (DNAR) form been completed?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Is a Do Not Attempt Resuscitation (DNAR) form with patient?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

---

**PLEASE REMEMBER TO FAX DNAR FORMS TO SOUTH WEST AMBULANCE TRUST ON 01202 851305**

<table>
<thead>
<tr>
<th>Advance Care Planning document status</th>
<th>Not yet given to patient</th>
<th>Passed to patient but not yet completed</th>
</tr>
</thead>
</table>
### Is a final days/End of life care pathway in use? e.g. Liverpool Care Pathway

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

### Has an Advanced Decision to Refuse Treatment form been completed?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

### Who holds it?

**Their Contact number**

### Does patient have any special requests or preferences?

### Does patient wish to avoid anything?

### Is patient under active hospital treatment/follow-up?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

### Details of Treatments refused and circumstances of refusal

### End of Life Details

#### Preference for place of death

<table>
<thead>
<tr>
<th>Home</th>
<th>Community Hospital</th>
<th>General Hospital</th>
<th>Care Home</th>
<th>Hospice</th>
</tr>
</thead>
</table>

#### Actual place of death

<table>
<thead>
<tr>
<th>Home</th>
<th>Community Hospital</th>
<th>General Hospital</th>
<th>Care Home</th>
<th>Hospice</th>
<th>Other (please provide details below)</th>
</tr>
</thead>
</table>

#### Reason for variance

#### Reason for patient leaving service

<table>
<thead>
<tr>
<th>Died</th>
<th>Discharged</th>
<th>Unknown</th>
</tr>
</thead>
</table>

#### Date of discharge/death

This form can be sent to the Somerset Care Coordination Centre for addition to the system

**Phone:** 01749 836550  
**Fax:** 01749 836528

**Email:** [endolifecare@sompar.nhs.uk](mailto:endolifecare@sompar.nhs.uk)
<table>
<thead>
<tr>
<th>Key Personnel</th>
<th>Informed of Addition</th>
<th>Informed of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please provide details, if known</strong></td>
<td><strong>Please tick</strong></td>
<td><strong>Please tick</strong></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Matron</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Palliative Care Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family (if appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR USE OF EMERGENCY INFORMATION TUBES

The emergency information tube is a plastic cylinder designed to hold essential information relating to a patient or person deemed to be vulnerable. It contains a form to be completed with relevant information, a reply paid audit card and two stickers. One sticker should be placed in a conspicuous area that may be seen on entering the home, but should not be visible from the front door. The second should be placed on the door to indicate where the tube is kept, preferably somewhere in the fridge for example, on a shelf or on the fridge door.

It is suggested that the DNAR form should be placed in the tube thus ensuring that it is kept in a universal container and is next to other vital information. The form can be rolled up and placed inside the tube; there is plenty of room to accommodate it.

Additional supplies of the tubes may be obtained from whichever agency is running the scheme in your area, Rotary Club, The Lions etc. In Somerset Partnership NHS Foundation Trust we are negotiating to have supplies placed in the hospitals, hospices or with the Palliative Care nurses.
Do Not Attempt Resuscitation documentation
Memorandum of multi-agency agreement

Background
Difficulties with Do Not Attempt Resuscitation (DNAR) documentation continue to cause problems for patients, their families and healthcare professionals. The Somerset Palliative Care Network, a county wide forum for the coordination and planning of palliative care services involving many organisations in Somerset, is aware of these difficulties and promotes this memorandum of agreement about DNAR documentation across the above named organisations.
Each organisation has its own DNAR policy, which this agreement does not seek to replace; neither is this agreement a policy about DNAR. It seeks to clarify what documentation is acceptable and how this should be managed.

The above organisations agree that:
1. They will recognise each other’s DNAR forms in all clinical settings.
2. They recognise that there will be at least 3 separate DNAR forms in use in Somerset; the SWAST form and forms from Musgrove Park Hospital & Yeovil District Hospital, plus some of the previous SWAST forms will still be in use in the community.
3. That in the community the current SWAST form should be used, ideally with the red border to make it easier to find, but that a black and white version remains valid.
4. That the form belongs to the patient and should travel with the patient between clinical settings. A photocopy of the form can be kept in the sending team’s notes. The original form should be with the patient.
5. That after transfer from one setting to another, the receiving team should review the patient’s DNAR status & complete a new form when time allows (i.e. during normal working hours), in the interim the existing form is valid.
6. That there is no requirement for a review within a set time frame and that a signed form remains valid until it has been cancelled, but that if the patient’s condition or wishes change the form should be reviewed.
7. A record of palliative care patient’s DNAR status should be recorded, with the patient’s consent, on the Electronic Palliative Care Coordination System (Adastra). If the patient is unable to give consent a ‘best interest’ decision should be taken.
8. That a copy of the form faxed to SWAST and held at The Hub has the validity of the original in the event of the original not being available with the patient.
9. That any clinician cancelling a DNAR order is responsible for updating SWAST and EPACCS.
DO NOT ATTEMPT RESUSCITATION POLICY CLINICAL AUDIT STANDARDS

04/04/2013

These standards apply to all Service Areas
<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Where patients are admitted to hospital acutely unwell or become medically unstable in their existing home or healthcare environment their resuscitation status should be considered and discussed with them as soon as is reasonably possible.</td>
<td>100%</td>
<td>None</td>
<td>A sensitive discussion relating to DNAR decision making should be held at the earliest opportunity on admission with a competent patient who is at foreseeable risk of cardiopulmonary arrest or has a terminal illness. The Mental Health and Social Care Directorate Admission Checklist (RCPA Policy Appendix K) states that in Older People’s mental health wards there should be a discussion within 24 hours of admission when this is indicated and that this should include reference to the existence of any advance decisions. The standards for the Community Health Directorate are set out in the ‘Admission, Transfer and Discharge Policy’.</td>
</tr>
<tr>
<td>2</td>
<td>The resuscitation status must be clearly documented for all patients.</td>
<td>100%</td>
<td>None</td>
<td>In community hospitals and other community services within the Community Health Services Directorate this will be clearly documented on the medications administration record (MAR or drug chart) on the back, clearly stating ‘For Resuscitation’ or ‘Do Not Attempt Resuscitation. Within the Mental Health and</td>
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<td>3</td>
<td>Any decision related to CPR should be communicated to the patient and / or relevant others if appropriate. The patient will also be informed of how this decision will be communicated to the wider clinical team.</td>
<td>100%</td>
<td>None</td>
<td>Social Care Directorate DNAR decisions will be recorded as a Rio Alert.</td>
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<td>4</td>
<td>The patient’s known wishes and decisions relating to attempting CPR should be communicated between health care professionals when a patient is referred or discharged for example between primary and secondary care.</td>
<td>100%</td>
<td>None</td>
<td>Where a DNAR decision has been made and there is limited discussion with patient because he or she has indicated a clear desire to avoid such a discussion, this must be documented in the patient’s notes. However all patients and / or relevant others if appropriate should be informed of the outcome and any DNAR decision that has been made including arrangements for communicating the decision to the wider clinical team and other healthcare agencies.</td>
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<td>5</td>
<td>If patients are transferred from one Trust facility to another, the doctor assuming medical responsibility for the patient’s care should review existing DNAR orders.</td>
<td>100%</td>
<td>None</td>
<td>Any DNAR decision must be made on current clinical information. This information should be reliable and up-to-date. A DNAR decision must be made on an individual basis. Standard rules or blanket policies are unlawful and cannot apply.</td>
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<tr>
<td>6</td>
<td>Prior to being commenced on the Liverpool Care Pathway the clinical team agree that the patient is dying naturally. Therefore, patients who have been commenced on the LCP should not be for CPR.</td>
<td>100%</td>
<td>None</td>
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<td>7</td>
<td>An advance decision relating to DNAR should be made in writing and it must be signed and witnessed. It must clearly state that it is to apply “even if life is at risk and death will predictably result”.</td>
<td>100%</td>
<td>None</td>
<td></td>
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<tr>
<td>8</td>
<td>With regards to incapacitated adults, people close to the patient should be kept informed about the patient’s health and be involved in the decision making in order to reflect the patient’s views and preferences.</td>
<td>100%</td>
<td>None</td>
<td>Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision making. If no relatives are available to consult one should involve an Independent Mental Capacity Advocate.</td>
</tr>
</tbody>
</table>
(IMCA). An advisory note from NHS Somerset and Advocacy in Somerset concerning involvement of IMCAs in DNAR decisions has however stated that there is no requirement to instruct an IMCA in an emergency situation or if it is very unlikely that CPR will be successful (i.e. if it would be futile); the decision must be based on the physical condition of the patient and reasons for not referring to the IMCA service should be recorded in the clinical notes. Where a valid Lasting Power of Attorney (LPA) exists, the LPA holder should be consulted on the treatment programme and whether CPR should be attempted; their view should be respected as if it were the incapacitated patient’s view (Mental Capacity Act, 2005).

9 There should be routine consideration of DNAR issues on admission to Mental Health and Social Care wards

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<td>9</td>
<td>There should be routine consideration of DNAR issues on admission to Mental Health and Social Care wards</td>
<td>100%</td>
<td>None</td>
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### DO NOT ATTEMPT RESUSCITATION POLICY CLINICAL AUDIT STANDARDS

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<tr>
<td>10</td>
<td>On making a DNAR decision a ‘Do Not Attempt Cardiopulmonary Resuscitation’ Form should be completed and forwarded by fax to the South West Ambulance Service NHS Trust (SWAST - Fax Number: see Appendix B).</td>
<td>100%</td>
<td>None</td>
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#### Definitions
(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)

- A record of the consultant review and the decision reached should be recorded in the progress notes (and any assessment of capacity should be recorded as stated in 5.30 below); the care plan should be amended and a RiO alert should also be made if there is a DNAR decision. A record should be made of assessment of capacity and of any discussions that have taken place with the patient and/or persons close to the patient, along with those with the wider healthcare team. This should be recorded within the RiO Consent and Capacity module. Any DNAR decision should be recorded as a RiO Alert.

- Mental Health services: A note should be made in the RiO Progress Notes that the form has been completed and a copy should be uploaded for incorporation into the document section of the patient RiO.
### Definitions
(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)

- The original red border paper copy should accompany the patient on discharge to be stored in nursing notes in care homes or in the emergency information tube in the patient’s own home. As stated in 5.4.3 above the patient and/or relevant others should be informed of this process including arrangements for communication with other agencies. A copy should also be scanned and retained in the Rio record.

- **Community health services:** Document all discussions in the patient’s notes detailing the circumstances that any decision relates to and who was involved in the decision making process. Record resuscitation status on the MAR Chart.

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<td>11</td>
<td>The patient’s GP or Out-of-Hours (OOH) service and the South West Ambulance Service NHS Trust should be informed whenever a DNAR order is made or a DNAR order is removed.</td>
<td>100%</td>
<td>None</td>
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<td>12</td>
<td>Reversal of a DNAR order should be recorded on the form; it should be scored through with a permanent marker to indicate the order is now obsolete.</td>
<td>100%</td>
<td>None</td>
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<tr>
<td>13</td>
<td>Where a patient with a DNAR form is being discharged home or is dying at home it is the medical and nursing team’s responsibility to ensure that the family are aware of its existence and know what to do in the event of the patient’s death.</td>
<td>100%</td>
<td>None</td>
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<td>14</td>
<td>DNAR decisions must be reviewed regularly.</td>
<td>100%</td>
<td>None</td>
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<td>15</td>
<td>The DNAR decision must be communicated to the GP on the discharge letter.</td>
<td>100%</td>
<td>None</td>
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