**ALL WALES DO NOT ATTEMPT CARDIO PULMONARY RESUSCITATION POLICY**

**Executive Lead:** Medical Director

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**Financial impact:** No significant impact

**Quality, Safety, Patient Experience impact:** If taken up across the UHB and Wales the policy provides an opportunity for significantly improved end of life care and patients being cared for at the end of their life in more appropriate care settings with dignity and respect.

**Healthcare Standard Number:** 1,7,8  
**CRAF Reference Number:** 8.2.3

**Equality Impact Assessment Completed:** Yes

**RECOMMENDATION**

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the all Wales DNACPR Policy for Adults in Wales
- **APPROVE** the full publication of the DNACPR Policy for Adults in Wales in accordance with the UHB Publication Scheme

The following documents can be found on the link below:

1. “Sharing and Involving” A Clinical Policy for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults in Wales
2. DNACPR Policy - Equality Impact Assessment
3. DNACPR Policy - Quick Reference Guide
4. DNACPR Policy - Information for patients and their carers to help make decisions about CPR (Cardiopulmonary Resuscitation)

[http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/251418](http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/251418)

**SITUATION**

Welsh Medical Directors have been involved in producing an All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy, Quick Reference Guide and Patient Information Leaflet (all these documents are available with this report). Welsh Health Boards are required to approve the policy for adoption in their organisation. Given the lateness of the receipt of the documentation, the UHB Board was not able to be appropriately sighted for its 4th November 2014 Board Meeting.
AGENDA ITEM 1.13a
A model Board paper has been produced to facilitate a consistent presentation and reflects recent discussions at the national implementation group to reflect:

- There will be a joint Welsh Government (WG)/NHS communication strategy – there will be a lead for the NHS, with liaison with all Health Board (HB) and Trust Communication Leads.
- A task and finish group is being convened to look at training issues on a national level.
- HBs and Trusts are being asked to establish their own local task and finish group internally to take forward the various strands of implementation and communication.
- HBs and Trusts are being asked to publish the document on their websites ahead of implementation from February 2015 in order to raise awareness from 1 December.

BACKGROUND

At the beginning of 2012 the Chief Medical Officer asked a core group of senior clinicians from across NHS Wales to review existing arrangements and to develop a unified approach across Wales for DNACPR. The publication of the NCEPOD Report ‘Time to Intervene?’ on 1st June 2012 gave added impetus to the need for a clear framework.

The UHB Board received the Policy at the last meeting on 4th November and was advised that the Quality, Safety and Experience Committee would be asked to approve the Policy at its meeting in December.

It is therefore important that all documents provided as a link to this paper are fully considered by the Committee Members in making their decision.

ASSESSMENT

The All Wales Policy, Form, Quick Reference Guide and Patient Information Leaflet have been developed through an extensive engagement process.

Taking account of best practice from other parts of the UK, the core group first produced a draft DNACPR Form and an algorithm to support decisions. This documentation was tested at three workshops held across Wales involving a wide range of stakeholders and clinicians.

The development of the all Wales framework for DNACPR has been grounded in the public sector equality duty principles of evidence; transparency; engagement and leadership to ensure that it impacts in a fair and positive way. Two stakeholder reference groups were arranged with support from colleagues in NHS CEHR to inform relevant third sector organisations of what was proposed. Focused engagement has also taken place with Mencap Cymru and the Older People’s Commission.

All Wales Medical Directors have been kept regularly informed of progress in the development of this all Wales Policy. The most significant difference to other current
**AGENDA ITEM 1.13a**

DNACPR policies is the inclusion of the concept of a Naturally Anticipated and Accepted Death where in less acute situations a gradual decline in clinical wellbeing is noted and in the context of the patient's condition, death might be considered clinically inevitable.

The policy and supporting algorithm ensure that every effort is made to involve the individual and/or those closest to them in a DNACPR decision. A standardised form will be introduced and will be used for recording adult DNACPR decisions ensuring effective communication of the individual's resuscitation status between all members of the multi-disciplinary healthcare team involved in their care across a range of settings. This will support the improvement of patient care by the prevention of inappropriate, undignified and potentially harmful CPR attempts at end of life but will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the individual's care or treatment. Monitoring and evaluation audits have been developed to support the policy's implementation and effectiveness.

The policy provides a decision making framework to ensure:

- the patient's wishes are respected.
- it reflects the best interest of the individual and provides benefits that are not outweighed by burdens.
- consideration, recording and communication of a patient's CPR status across health professionals.

To ensure consistency across Wales and to support the implementation of the policy a Quick Reference Guide for clinicians and a Patient Information Leaflet have been produced. An all Wales communication strategy is being developed jointly with Welsh Government to emphasise the importance of, and to ensure consistent messages relating to the policy and its implementation. An All Wales task and finish group will look at the various strands of training that will be required and what can be produced on a national basis. Wide consultation has taken place to ensure that the policy/procedure meets the needs of Welsh stakeholders and the Health Board. The consultation was undertaken on an all Wales basis.

The primary source for dissemination of this Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.
“Sharing and Involving”

A Clinical Policy For Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults In Wales

Issue Date: October 2014
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DNACPR Form (Adult) DO NOT ATTEMPT CARDIO-RESPIRATORY RESUSCITATION (DNACPR) DECISION is included at the end of this document.
1. Introduction and Objectives

Cardio-respiratory resuscitation (CPR) can, in theory, be attempted on any person following a cardiac arrest. However, the clinical outcome is largely dependent on the individual clinical factors that led to the arrest. In many instances the procedure does not result in a good clinical outcome. There is significant risk of harm and prolonged suffering from CPR - including long term neurological effects and the need in some cases for prolonged admission to ITU and a possible further cardiac arrest resulting from the underlying disease process.

Inappropriate attempts at CPR can lead to unnecessary distress for patients, their family and trusted friends, may involve the Ambulance Service and even the Police which can clearly cause further distress.

The clinical intervention of CPR as a result may not be appropriate for all patients. It therefore follows that a decision not to attempt CPR should be reached on the basis of a proper, appropriately informed, discussion with patients involving those who are particularly important to them.

There has been increased focus on matters relating to Do Not Attempt Cardio-respiratory Resuscitation (DNACPR). This is possibly a reflection of the fact that the clinical and ethical issues are acknowledged to be of such an important and personal nature. Whilst we meticulously plan care with patients for interventions at the beginning of life, all too often we fail to have equally important discussions relating to a patient’s wishes at the end of life. Frequently it seems that there is too little discussion - too late.

A quick-reference document, which should be read in conjunction with this policy, is provided comprising a summary of the key elements of this policy, along with an information leaflet for patients, relatives and those closest to them.

1.1 Purpose and Scope of this Policy

This policy applies to all NHS Wales staff and the care of patients of 18 years of age and over in all care settings within the remit of NHS Wales. It specifically relates to cardio-pulmonary resuscitation (traditionally referred to as “CPR”), synonymous with cardio-respiratory resuscitation which is the attempted restoration of circulation and breathing in someone in whom both have stopped. It does not apply to other treatments and care, including procedures that are sometimes loosely referred to as ‘resuscitation’ such as rehydration, blood transfusion, intra-venous antibiotics etc.

NHS Wales is responding to the need to introduce substantial improvements with regard to DNACPR decisions involving adults in order to achieve more appropriate patient-centred care. The focus is on respect for the wishes of individuals in order to facilitate the provision of appropriate care at the very end of life and the need for discussions to take place in a shared and planned way, at an earlier stage, across all settings including the home and community.

The purpose of this policy is to provide a framework for professionals and NHS bodies in Wales to facilitate a consistent approach to decisions about the provision of CPR. This policy is compatible with Welsh policies on organ donation and consent. While death is inevitable, achieving a dignified, sensitive and shared approach to reaching a decision relating to CPR is vital for patients, their families and their close friends. DNACPR decisions should always involve senior professionals. DNACPR discussions can be challenging and they should be conducted in a calm, professional and reflective manner.

Workshop Comment:

“It should become more of a routine to ask of a patient’s wishes about resuscitation”

“This policy hopes to start a more open dialogue in relation to patients’ wishes at the very end of life”
The decision not to attempt CPR on a patient is a **major clinical decision**. The clinical course leading up to this point may be of short duration for some patients. For others it may follow a more gradual decline in health.

The decision as to whether a patient would want physical attempts (CPR) to maintain their circulation and breathing in the event of a cardiac arrest is also a **serious personal decision**. In most cases a DNACPR decision will be made after a careful, planned discussion in partnership with the patient and involve those closest to them. Decisions relating to DNACPR must be accorded a high level of prominence to ensure that discussions are allocated sufficient time.

It is possible to identify those patients in whom cardio-respiratory arrest represents the natural end to their illness. **A “clinical concept” of a Natural Anticipated and Accepted Death (NAAD)** is introduced in this policy in order to offer guidance to clinicians as to when to consider a discussion in those cases where CPR would represent an unsatisfactory, undignified and clinically inappropriate intervention – or possibly where the burden of CPR in clinical context clearly outweighs realistic benefit. An individual patient-centred approach is vital. The patient’s fully informed personal perspective on CPR is of great importance, viewed in the wider clinical context. It is also very important to identify those patients who adamantly refuse CPR, following informed discussion.

This policy has been developed in partnership with key clinical and non-clinical stakeholders in order to develop a consistent approach to DNACPR across the NHS in Wales and to ensure that the decisions reached are based on an individual patient's needs. It outlines an open, personal approach to DNACPR decision-making in Wales, an approach understood by clinicians, patients and their families - acknowledging the particular circumstances of every patient.

**Objectives of this policy:**

The overriding principles of this policy are:

1. To ensure an individual’s life is respected and valued.
2. To ensure early senior clinical involvement and accountability in the decision making process.
3. To make clear that a DNACPR decision must not prejudice any other aspect of care.

The primary objectives of this DNACPR policy are:

- To ensure that this important discussion is accorded the highest level of significance.
- To develop across NHS Wales the approach of consistent planning with regard to CPR as an intervention being based on an individual plan for every patient.
- To ensure an integrated approach to making DNACPR decisions.
- To ensure that an individual patient plan is in place across all relevant care settings.
- To ensure correct and effective communication to all those involved in the patient’s care.
- To ensure that decisions regarding CPR are made taking into account:
  - Whether CPR is likely to succeed
  - The clinical needs of the patient
  - The patient’s wishes
  - Sound ethical principles
  - All relevant legislation (for example the Human Rights Act (1988) and the Mental Capacity Act (MCA) 2005 and the duties and obligations set by professional regulators.

**Workshop comments:**

“All too often - DNACPR discussion seems to be “too little - too late”.

“The complications of CPR and also the concept of natural anticipated accepted death should be more openly discussed”
• To make DNACPR decisions in a transparent way that is open to examination.
• To avoid inappropriate CPR attempts in all care settings.
• To ensure staff, patients, their trusted friends and family have appropriate information on making advance decisions relating to CPR and that they are able to discuss resuscitation issues when they wish to do so and that they understand the process.
• To clarify that patients will not be asked to decide on CPR when it would be highly likely to fail - although they should be informed.
• To ensure that clinical staff who are caring for people with communication difficulties or who may be vulnerable will provide a decision making process that is clear and appropriate for their needs.

Audit Point 1 – The ‘nature’ of a DNACPR decision and the importance of good communication

Clinical staff must understand the personal implications of a DNACPR decision. Achieving this requires clinical reflection, excellent communication and informed decision making. If personal discussion with the patient is not possible (including for reasons of mental capacity) the same principles must apply.

2. Definitions

Throughout this policy “DNACPR” refers solely to the provision of Cardio-pulmonary resuscitation and not to any other aspect of the individual’s care or treatment options.

2.1 Cardiac Arrest

This is the sudden cessation of a clinically detectable cardiac output.

2.2 Cardio-Pulmonary Resuscitation (CPR)

CPR is an intervention delivered with the specific intention of restoring and maintaining circulation and breathing. CPR is a physical and relatively invasive process. It usually comprises chest compressions with the mechanical ventilation of the lungs, possibly defibrillation by electric shocks and the injection of medication. It is increasingly referred to in the literature as cardio-respiratory resuscitation.

2.3 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

This refers to a specific advance decision NOT to initiate CPR in the event of a cardiac arrest. It must be made clear to the patient, those close to the patient and also to the health care team that a DNACPR decision does not have repercussions on any other element of care.

2.4 Joint Statement (see section 11)

The joint statement refers to the BMA, Resuscitation Council (UK), and RCN’s report - “Decisions Relating to Cardio-pulmonary resuscitation” (2014). This update of earlier guidance represents a very important UK document in this clinical arena.

2.5 Mental Capacity

The Mental Capacity Act 2005 Section 1(2) recognises the basic principle that an adult must be presumed to have the capacity to make their own decisions unless it can be established that they are not able to understand, use or weigh up the information needed to make the DNACPR decision and/or communicate their wishes. A person must be assumed to possess the mental capacity to make a particular decision unless the reverse can be positively demonstrated for that specific decision. Identifying early on in the course of an illness the possibility that the patient may, at some time in the future, lose the capacity to decide for themselves will ensure that, wherever possible, a well-informed DNACPR decision can be reached or, where appropriate, achieved in the patient’s best interests.
2.6 Independent Mental Capacity Advocate (IMCA)

If the patient who lacks the mental capacity to take the specific decision does not have family or friends who are willing, and able, to be consulted an IMCA should be instructed. Please refer to your MCA lead when required.

2.7 Advance Decision to Refuse Treatment. (ADRT)

This refers to a decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding. Note that neither the patient, nor anyone on their behalf can insist on treatment that the clinical staff do not feel is in their best interests even if such insistence is included in a written document. Refer to the Mental Capacity Act and the Code for further details and in the event of uncertainty with regard to the validity of the document seek legal advice.

2.8 Lasting Power of Attorney for Health and Welfare or Court Appointed Deputy

Both of the above may have legal powers to assist with the decision making process where the patient lacks capacity. However, care should be taken to check the validity of any held documentation and the scope of their powers. Where such persons are considered not to be acting in the patient’s best interests it is important to seek legal advice.

3. Policy development and implementation

3.1 Process of policy development

This policy was developed following a series of meetings to evaluate current local policy positions across Wales, and through meetings with health professionals, patient groups and key national stakeholders. The process of development included clinical workshops in North Wales, West Wales and South-East Wales testing and adjusting the discussion framework and the All Wales DNACPR form. Members from a wide range of clinical communities were represented and a broad range of non-clinical stakeholders were engaged through stakeholder events. A consistent theme received at events was that a policy must reflect a culture of “openness and candour” when a clinician broaches the subject of DNACPR – a culture which also affords the opportunity for patients and those closest to them to raise the subject of DNACPR themselves.

The approach to developing this policy has been grounded in the public sector equality duty principles of evidence, transparency; engagement and leadership in order to ensure that it impacts in a fair and positive way. Engagement with a range of third sector organisations has raised awareness of issues relating to DNACPR and this policy is a product of this wide engagement.

3.2 Principles of policy implementation

Health professionals across NHS Wales must be made aware of this policy and also of their responsibilities to patients and those closest to them in order to meet the standards required. Staff should be made aware of this clinical policy through training measures (see section 10) employing Local Health Board mechanisms in accordance with the local management of policies and procedures. This requires Health Boards to work closely in partnership with the other key organisations including the Welsh Ambulance Service. Staff must operate this policy within NHS systems of information governance, with the clinical information relating to DNACPR being accessible to those teams providing clinical care for the patient.
4. **DNACPR in practice – key principles**

4.1 **When DNACPR status is unknown**

Unless a valid DNACPR decision is in operation with either a completed All Wales DNACPR form or a valid Advance Decision specifically to Refuse Treatment (ADRT) (relevant to the CPR decision) exists all patients must be presumed to be “for CPR”. If a significant possibility of a cardiac arrest or death cannot be envisaged, then there is no medical decision to make.

4.2 **Circumstances when CPR would not restore circulation and breathing**

If the senior clinician in charge of the patient, in liaison with the clinical team, are as certain as they can be that CPR will not re-establish effective circulation and breathing in the patient then CPR should not be offered or attempted. When this is the case, discussion with the patient should take place in the spirit of good practice and openness. For some patients there may be individual clinical circumstances where such discussion might lead to harm and not provide relief; in such circumstances the clinical reasons for avoiding discussion with the patient must be clearly documented.

4.3 **DNACPR Discussion – openness, with confidentiality and in partnership**

All patients faced with this discussion require support from those providing care. Whenever possible, with patient consent, the person(s) they have chosen to be involved in their care and treatment should be invited to be present during the discussion. The clinician must be aware of the current clinical status and the benefits and risk of harm from CPR. A discussion can ensue and a shared decision can then be reached in partnership. Patient confidentiality must be respected at all times.

All competent patients have the right to refuse to participate in DNACPR discussions. They can also refuse permission to share the outcome of the discussion with any third party. Such decisions must always be respected and documented in the patient’s records. A clinician should not force information on a patient which is likely to cause harm. A risk of harm in this context, or an indication from the patient that they do not wish to be informed about CPR, must be justified in the clinical record.

4.4 **DNACPR Discussion – communication with those close to the patient**

Whenever clinically possible, all patients should be offered the opportunity of support from a close individual for the DNACPR discussion. A decision to refuse such an offer of support must be respected and recorded. Individuals close to the patient will naturally be anxious about them and whenever possible should be kept informed of the clinical progress of the patient. Whilst such discussion between the patient and those closest to them are to be encouraged, if a private DNACPR discussion is requested by the patient, it is sensible at its conclusion to confirm with the patient whether they wish the conversation to remain in confidence. You must respect the position and record that decision in the clinical record.
4.5 **Documentation of the DNACPR discussion:**

The standard All-Wales documentation for adult DNACPR decisions must be used in the NHS Wales in order to reduce risk and to aid clear communication about the decision.

4.6 **Wider communication of DNACPR decisions:**

Immediate and effective communication of a DNACPR decision must take place so that all those involved with current and future care are made aware. It is the responsibility of the senior responsible clinician when countersigning the DNACPR form, to ensure appropriate communication. The original document must be prominently placed in the patient’s current medical record. For all settings this may include raising awareness outside the immediate place of care (see section 6.4).

5. **Making a DNACPR Decision**

5.1 **When should a DNACPR discussion be contemplated?**

Recognising the right time to consider DNACPR may not be easy but an anticipated cardiac arrest or death in light of the current illness forms its basis. Understanding wishes expressed by the patient represents a fundamental element of good care and making DNACPR decisions *before* a patient becomes too unwell or loses the capacity to make the decision should be the aim. This requires the establishment of a bond of trust with the patient, family and those close to them.

The discussion should usually be conducted by a senior team-member. If no DNACPR decision is in place and no specific Advance Decision on CPR exists (i.e. the wishes of the patient are not known) the presumption is that CPR will be provided. This applies unless at the time of an arrest the clinician is certain that they possess sufficient information about the patient to judge that CPR cannot be successful.

**Audit point 2 – Clinical teams require time to discuss DNACPR issues**

An anticipated cardiac arrest or death should instigate team discussions to identify those patients with whom a DNACPR discussion is warranted. This should become part of clinical routine – so that DNACPR is usually discussed before the need for an urgent response.

**Workshop comment:**

“The “appropriateness” of a "CPR call" is not usually one for the resuscitation team”.

Clinical presentations can be highly variable. In some cases the level of physiological compromise at presentation indicates a likely imminent decline to a cardio-respiratory arrest. For others a more gradual deterioration may be the anticipated course. Sometimes a decline in health may be first suspected by carers and those closest to the patient and occasionally by the patient themselves. These represent common general clinical scenarios when a DNACPR position might initially be considered.

**Audit point 3 - Team discussion relating to DNACPR**

The possibility of a cardiac arrest should lead to a team discussion relating to DNACPR - with an additional community perspective whenever possible. The clinical decision framework (section 5.2) may be a helpful guide. The decision to move to a DNACPR discussion should be recorded. The DNACPR discussion itself should take place as soon as possible thereafter (within 12 hours).
5.1.1 **If CPR will not restart the patient's heart and maintain breathing**

If the clinical team is *as clinically certain as possible* that attempting CPR would not re-establish effective circulation and maintain breathing then CPR need not be attempted. A patient cannot demand a treatment that is not clinically indicated. To provide CPR in such circumstances would be futile. The decision is a clinical one centred on the clinical picture at the time. The position should be communicated to the patient (see section 4.3) and, with consent, to those close to them.

5.1.2 **If the potential “adverse effects” of CPR outweigh any potential benefits**

Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient. The patient’s recently expressed wishes are very important to ascertain. Teams, in this case, should also consider whether a natural death free from the invasive intervention of CPR may be in the patient’s best interests which could, with agreement, result in a Natural Anticipated and Accepted Death (NAAD).

### Audit point 4 – Consider the possibility of “NAAD / DNACPR”

All salient clinical aspects must be considered and discussed in order to help reach a clinically informed and a shared decision. It may be possible to conclude that the situation should be managed as a Natural Anticipated and Accepted Death (NAAD). NAAD is a “clinical concept” which may help clinicians and patients in partnership reach a shared position from which a DNACPR follows.

5.1.3 **When a valid and applicable Advance Decision to Refuse Treatment (ADRT) by CPR exists**

Patients should be asked at an early stage of contact if they have made an ADRT in relation to CPR. There is an expectation that patients and/or their families will endeavour to ensure that healthcare teams are made aware of the existence and content of any specific Advance Decision. If there are reasons why the attending clinicians believe an Advance Decision to be invalid or inapplicable this must be carefully documented within the patient’s record. When a patient is known to have a valid and applicable ADRT, at an appropriate time a DNACPR form should be completed. Where the existence of an Advance Decision is unknown with no time to investigate - the presumption is for attempting CPR, if this is considered to have a realistic chance of benefit.

### Audit point 5 – CPR-specific Advance Decisions – identification at point of contact

It is important to ascertain the existence of a specific ADRT for CPR at an early stage. This will ensure continuity of knowledge throughout the patient’s journey and prevent inappropriate arrest calls.

5.1.4 **Status of a DNACPR decision in a high risk clinical intervention**

Any person over 18 years, who has the requisite mental capacity, can refuse treatment. If a patient with capacity refuses CPR, even when it may result in benefit, this must be carefully and clearly recorded in the patient’s record. If a patient wishes a DNACPR decision to remain valid during a procedure or treatment that by its nature increases the risk of cardio-respiratory arrest (e.g. cardiac surgery), this will possibly impact on the risks of the procedure. If the clinician undertaking the procedure believes that the procedure or treatment will be too high risk with the DNACPR decision still in place then detailed discussion must take place. In some cases the higher risk will mean that it might be clinically reasonable not to proceed (see section 8.2).
5.2 Framework for a DNACPR Decision

* Trigger – may represent a traditional “clinical trigger” where the clinician envisages a possible cardiac arrest as a natural consequence of the condition—or when the harm or risks of CPR clearly exceed the benefit.

**see Para 7.30 MCA (2005) guidance – health and welfare attorney must be designated to cover life-prolonging treatment decisions and be registered with the office of the public guardian. If no ADRT is in place consider section 5.4 and MCA.

*** Note: Patient may change his/her mind at any time. Also for interventions with significant risk of cardiac arrest, a CPR discussion must occur when obtaining informed consent for the procedure.
5.3 How a DNACPR discussion should be conducted

The patient is the priority and must be at the centre of the discussion. For this reason, the initial approach made concerning DNACPR, must be with great tact, with sensitivity, and always with forethought to any communication and language needs. DNACPR discussions must be based on a spirit of candour, openness and trust armed with clear clinical knowledge of the patient. The approach to the discussion should always bear in mind the emotional needs of the patient and those most close to them. A DNACPR discussion should never be rushed and should be approached with recognition of the individual’s particular circumstances, values and beliefs.

Audit point 6 – A named individual for “close support”

Those closest to the patient (not always immediate family members) can provide valuable personal insight. It is essential for all patients to be asked to provide the name of someone they wish staff to deal with in the event of significant change in their condition and for this to be recorded.

Audit point 7 – The DNACPR discussion (preparation, time and privacy)

Senior clinicians must allow adequate time for DNACPR discussions. They should possess knowledge of the patient’s history and the clinical evidence-base/rationale for the discussion. The conversation should be as private as circumstances allow. The conclusion should be understood by the patient. A nominated team-member should offer further contact with the patient to enquire if clarification is necessary.

5.4 DNACPR and mental capacity:

The Mental Capacity Act (2005) defines the rights of patients and describes the responsibilities of those who provide care. It reinforces the understanding that people who lack the capacity to make their own decision about the specific issue at hand must remain at the centre of decisions that affects their lives.

Impaired function of the mind or brain is common in many medical conditions and care must be taken to ensure that those who assess decision making capacity have the appropriate level of skill.

Cases where capacity may be impaired demand a reflective approach from the senior responsible clinician. The first step in the process must be to perform a robust assessment of mental capacity. Whilst this can be performed by any clinician with the appropriate skill, in complex cases liaison psychiatry can sometimes be very helpful. Where the patient is found to lack capacity the current views of the patient should still if possible be taken into account as well as the views expressed before capacity was lost. Decision makers should also consult those closest to the patient. Where this is not possible and where there is no lasting power of attorney (LPA) an independent mental capacity advocate (IMCA) should usually be appointed. This will help ensure that personally appropriate decisions are made and ensure independent safeguarding of the process (refer to the Mental Capacity Act and the Code for more detail).

A DNACPR decision must never be implemented purely on the basis that the patient lacks capacity. All NHS staff must take responsibility for applying the same standard in relation to DNACPR to all
patients.
If a patient lacks capacity and a decision is made in his or her best interests in accordance with the MCA then the clinical rationale and justification for the best interest decision should be clearly recorded in the notes by way of a best interest's balance sheet if at all possible.

Audit point 8: Raised awareness of the possibility of impaired mental capacity

A patient with altered capacity might display behaviour(s) not necessarily correlated with the usual clinical “reference points”. In such cases, where DNACPR is being contemplated, input from those closest to the patient, carers and trusted friends is essential for understanding.

Audit point 9: Mental capacity and mental health

Clinical staff should also be aware of the effect that concurrent mental health conditions might impact on a patient’s capacity. If it is felt that a significant psychological co-morbidity exists, specialist psychological assessment prior to DNACPR discussion should be considered.

5.5 Deciding that a case warrants a DNACPR decision

The DNACPR discussion framework is illustrated on page 11. This includes clinical events that might act as a “trigger” for a team-based DNACPR discussion. It also outlines questions clinicians should ask themselves in order to decide whether a clinical situation is one which might lead to a DNACPR discussion with the patient.

5.5.1 DNACPR:

In some cases it will be clear that the clinical position is irreversible and that a cardiac arrest is inevitable. Such circumstances for example could occur in the urgent acute setting or following the rapid irreversible decline of a known previously stable condition. The conclusion of the clinical team might be that it would not be in the best interests of the patient to attempt CPR. A DNACPR decision can then be made. Unless there is very good reason to the contrary, the clinical basis should be discussed with the patient and, with consent, also the individual chosen by the patient to be involved and a DNACPR decision with clinical reasoning clearly documented. Discussion with regard to organ and/or tissue donation should be considered in line with the current All Wales policy.

5.5.2 NAAD (Natural, Anticipated and Accepted Death):

In less acute situations, a gradual decline in clinical well-being may be noted and ultimately death as a result of the current disease process may be envisaged. Accordingly, in the context of the patient’s condition death might be considered to be clinically inevitable. The patient may or may not be receiving some care from palliative specialists. The team’s reflection might be that death is the consequence of the disease process itself (natural) and is reasonably envisaged (anticipated) to occur in the near future.

When such a patient has capacity a discussion with the patient should take place, and if there is consent, with the person they have chosen to be involved in their care and treatment. A joint position on a Natural, Anticipated and Accepted Death (NAAD) may be the agreed shared position. NAAD is not a conclusion in itself. It would however represent a clinical position from which a DNACPR position follows. It is NOT a decision for the alteration of any other aspect of care and it should lead to further discussions as to how appropriate care can be achieved. If a NAAD is reached, it is vital that it is conveyed to the patient and those closest to them that this would usually lead to a DNACPR decision, together with a clear explanation that “all clinically appropriate care will be provided”.

Workshop Comment:

“NAAD represents a tripartite system – recognising the natural course, one that is clinically envisaged and where there is an agreed, shared, position”
Many DNACPR decisions take place against a clinical context of chronic illness with gradual deterioration and multiple co-existing illnesses. In these circumstances, a planned fully informed discussion can take place. In all care settings the discussion must cover the risks and the burdens as well as the likely outcome from CPR. A mutual understanding of matters by the patient, those individuals close to them and the clinician is essential. A position of a Natural Anticipated and Accepted Death might be reached leading to a DNACPR decision.

5.5.3 DNACPR – for a patient with an ADRT:

A patient may have a specific Advance Decision in place with previously expressed wishes withholding permission to attempt CPR in the event of cardiac arrest (see 5.2.3). Where known this information must be shared with the clinical teams caring for the patient. A copy of the Advance Decision should be attached to the back of a completed DNACPR form. Where the patient lacks mental capacity and where no specific Advance Decision exists the default position is to provide CPR.

Audit point 10 – Involving relatives and those closest to the patient

Teams must respect the knowledge and concerns expressed by those closest to the patient. Before discussing DNACPR patients should be asked if they want the support of a named person. If the patient declines this should be clearly recorded and a desire for confidentiality must be fully respected.

5.6 Who should have the DNACPR discussion with the patient?

A senior team member should be nominated for the role. The professional undertaking the discussion should immediately record the discussion on the All Wales DNACPR form and ensure (if they are not the senior responsible clinician) that this is countersigned by the senior responsible clinician at the earliest reasonable opportunity. When the senior team member is a medically qualified professional the DNACPR will become active when signed, timed, dated and following entry of the GMC number (section 5 - All Wales form). In all other circumstances sign off (with GMC number) by the senior responsible clinician is necessary for the DNACPR to be active (section 6 - All Wales form).

Audit point 11 – The All-Wales DNACPR form

For DNACPR to be recognised in Wales (outside of a valid and applicable ADRT) the All Wales DNACPR form (see section 6) must be completed. It forms the record of the DNACPR discussion. The clinician completing the form (when not the senior responsible clinician) must sign the form (element 5 of form) and ensure countersignature by a senior responsible clinician as soon as possible (element 6). A GMC number is essential for the form to be active.

5.7 Requirements of the senior responsible clinician

A senior responsible clinician, in relation to this policy, must be available for all settings and will usually be a consultant or general practitioner. In some circumstances, senior nursing staff in secondary care and also in community settings may adopt some functions of this role in relation to this policy (but always with agreement and additional oversight by a senior responsible clinician).

They MUST:

- Be clinically registered and familiar with this policy.
- Ensure appropriate involvement has taken place both with the patient and those close to them.
- Ensure proper documentation is in place.
- Verify a decision made on their behalf at the earliest opportunity (by medical countersignature with GMC number.
- Ensure communication of the decision to the relevant clinical teams.
5.8 Senior oversight for every DNACPR decision

The senior responsible clinician will usually be the patient’s GP in the community or a consultant caring for the patient in secondary care. The senior responsible clinician is responsible for overseeing the documentation and communicating decisions. An agreed DNACPR position must be relayed to the senior responsible clinician in a timely manner, with information that a DNACPR discussion has taken place and an All Wales form completed.

If this clinician is not physically present at the time of the discussion the fact they have been informed must be clearly recorded on the form. The process of countersignature is not necessary if the senior responsible clinician has had the original discussion and completed the form. This process ensures senior clinical overview.

Audit point 12 – The DNACPR decision and oversight by a senior clinician

A senior responsible clinician should be made aware of, and countersign, the completed DNACPR form. Out-of-hours a senior clinician must be available and informed as soon as appropriate that a DNACPR discussion has taken place. In the acute situation the DNACPR discussion will often be undertaken (and the form completed) by the senior responsible clinician.

5.9 Responsibilities of the senior responsible clinician:

The senior responsible clinician who countersigns the form is clinically responsible for the agreed position. This senior clinician has additional responsibilities: to ensure the correct communication of a DNACPR decision, and to help ensure (with other team members) that the needs of those closest to the patient are being met. The senior responsible clinician should also be the reference point for any significant clinical questions or difficulties that might arise relating to a DNACPR decision.

Workshop Comment:
“Primary care must be made aware of all DNACPR decisions on their patients”

6. The All-Wales DNACPR Form

6.1 Documentation of DNACPR decisions:

The All Wales DNACPR form is the only agreed form for recording DNACPR decisions across NHS Wales.

All relevant sections of the form must contain entries. It specifically relates to DNACPR decisions and must form an integral part of the medical record. Do Not Attempt Cardiorespiratory Resuscitation (DNACPR) forms must be adequately completed and contain up to date information. The form should be filled out in black ink/ball-point, with legible handwriting and also signed, dated and timed.

“The proper recording of discussions related to DNACPR is vital and engenders confidence in the system” (Older People’s Commissioner Wales)

6.2 Whole-system recognition of the All Wales DNACPR form

The All Wales DNACPR form is recognised across all NHS sectors in Wales. When a DNACPR decision has been reached a signed and dated copy of the All Wales DNACPR form must be handed to the patient, or their advocate and the original must be prominently placed in the patient’s health record with copies relayed to other parties (see section 6.4).
6.3 The completed DNACPR Decision

A DNACPR decision is a specific clinical position that requires correct communication.

Audit point 13 – Completing the All Wales DNACPR form

All sections of the form must have a clear entry. Senior responsible clinicians must check this is the case when initially informed and always prior to countersignature.

6.4 Data capture and communicating the DNACPR Decision

Local Health Boards should ensure that the out of hours services, emergency departments and primary care practices have systems that can adequately store, coordinate, manage and respond to DNACPR data. This should include a protocol for alerting the Welsh Ambulance Service when patient transport is requested for a patient with a current DNACPR decision.

“The correct communication of DNACPR decisions is vital to meeting the patient’s needs” –Welsh Ambulance Service Trust

When a DNACPR decision has been reached in the hospital setting:

1. The original form should be prominently placed in the patient’s medical record.
2. A marked copy should be handed to the patient or their advocate for personal ownership.
3. A marked copy should be forwarded to the patient’s GP who should inform the out of hours provider.
4. A photocopy should be handed to ambulance personnel when transported from a hospital setting.

When a DNACPR form has been completed in the home or community setting:

1. The original form should be forwarded to the patient’s GP, who should place it in the medical record and inform the out-of-hours provider.
2. When relevant a marked copy should be retained in the records of a nursing/care home.
3. A marked copy should be handed to the patient or their advocate for personal ownership.
4. A copy should accompany the patient whenever care transfers to secondary care to be entered into their case record.

Ambulance control should also be verbally informed of the existence of a DNACPR order at the time of booking an ambulance. Whenever possible a photocopy should be handed to ambulance staff when being transported.

Audit point 14 – Communicating a DNACPR decision

DNACPR decisions must be shared with clinical teams that are likely to be involved in a patient’s on-going clinical care. Correct communication is essential. Processes for sharing DNACPR information must satisfy best information governance practice.

Communication with those closest to the patient must be unhurried, undertaken with patience, tact and with sensitivity for the situation.
7. **Review of a DNACPR decision**

7.1 **Review of a DNACPR decision**

When necessary a review should normally be undertaken by a senior responsible clinician. When a review has taken place this should be recorded on the All Wales form.

A DNACPR decision review should always take place if one is requested by the patient. A review of the DNACPR decision should also be clinically considered when a patient’s overall condition significantly improves warranting further discussion. The details of the review should be recorded in the patient’s clinical record and the date recorded on the All Wales form. If the clinical circumstances clearly change a decision may need to be cancelled (see section 7.3) or a new form may need to be completed. This decision will be subject to the same information sharing as the initial decision ensuring the updating of all records with the new copy of the DNACPR form and, again, a copy of the new form must be handed to the patient or their advocate.

7.2 **Urgent DNACPR reviews**

All patients must feel able to request a review of a DNACPR decision at any time. This includes those patients with reduced mental capacity, where either the advocate or named family members can request a review. **All such requests must have “urgent” status.** In some cases an unforeseen, sudden and sustained improvement in clinical status can occur and a review of the position may become necessary. In such circumstances, once clinically recognised, a review should take place.

**Audit point 15 – DNACPR review**

All patients with an agreed DNACPR decision will be subject to a clinical review as part of the normal course of events. Efforts should be made to ensure that patients are aware that a request for review of a DNACPR decision can be made at anytime.

7.3 **Cancellation of a DNACPR decision**

In some circumstances it may be appropriate to cancel a DNACPR decision. If this is necessary then the original form should be clearly crossed through with 2 diagonal lines in black ink with “CANCELLED” written between them. **The relevant section (section 7) of the form must also be completed and signed by a senior responsible clinician. All recipients of the DNACPR decision form (listed on the back of the original form) must be notified immediately that the decision has been as cancelled.** The communication must be in writing and logged in all relevant records and where possible contain a copy of the overwritten cancelled original document. The patient’s copy of the original form should be returned and filed in an envelope in the case record to reduce risk. If destroyed (usually by shredding) this must also be recorded.

8. **Special circumstances related to DNACPR**

8.1 **DNACPR decisions and high-risk invasive procedures**

When individual patients are very unwell some pre-planned invasive procedures may substantially increase the risk of a cardio-respiratory arrest (examples include: general anaesthesia, a pacemaker insertion, cardiac catheterisation, or surgical procedures). When such interventions are being contemplated for patients with an agreed DNACPR in place, the “current DNACPR position” must be reviewed with the patient in advance of the procedure. A decision to suspend the decision temporarily must be communicated with the patient or the patient’s representative (if the patient has reduced mental capacity) and the wider clinical team and recorded.

Some patients may want an agreed DNACPR decision to remain valid despite the increased risk of a cardio-respiratory arrest and despite foreseen potentially reversible causes; others may agree that the
DNA
cPR decision should be
suspended temporarily. A
decision as to how to proceed with the
procedure in such cases is a matter for professional judgement and must follow informed discussion.

Audit point 16 – DNACPR Case for automatic review - Example 1:

An agreed “DNACPR position” must be considered by the clinician undertaking an intervention that could impact on the risk of a cardiac arrest.

An agreed temporary change to the DNACPR status (covering the intervention and the immediate post-intervention period) must be clearly communicated to all relevant teams. Any new “temporary” position must also be included in “peri-operative checklists” and be communicated clearly to recovery teams.

The post-intervention clinical course must dictate when the original DNACPR position is re-established with all necessary teams appropriately informed.

8.2 Unpredictable, unforeseen and reversible clinical events

A DNACPR decision relates specifically to wishes expressed in the event of an anticipated cardio-respiratory arrest. The decision applies only to CPR and not to any other aspect of treatment.

In clinical practice however unpredictable emergency situations can occur in patients who have a current DNACPR in place. These include for example, acute, unforeseen and immediately life threatening situations such as reversible anaphylaxis, choking or a completely blocked tracheostomy tube. In such instances the underlying cause requires maximal treatment and temporary CPR might become necessary whilst any reversible cause is correctly managed.

Audit point – 16: DNACPR Case for automatic review – Example 2:

When clinical circumstances are NOT those envisaged during the original DNACPR discussion and in the event of an unpredictable acute and reversible cause of deterioration followed by cardiac arrest, the DNACPR decision does not override clinical judgement. Judicious senior clinical intervention is vital in such cases - with the clinical response subject to professional justification and review.

8.3 A clear request for CPR – when CPR is not clinically in the patient’s best-interest

A patient might insist that CPR is provided - even when (for clear clinical reasons) the clinical team feel it to be an intervention which cannot provide clinical benefit. When a patient requests CPR following a discussion that clearly outlines very significant risks and burdens, the senior clinician must record fully the patient’s expressed wishes alongside their own clinical views. When conflict exists and whilst further advice is sought the interim position should normally be to provide CPR. Efforts should quickly be made to reconcile the position if at all possible. In some cases a “team review” might resolve to respect the patient’s wishes in an individual case, and to provide CPR. In others however it might conclude that attempting CPR in the circumstances would be clearly contrary to best clinical judgement and good practice. In such cases, a second opinion must always be offered and legal advice may become necessary with further discussion with the patient. When there is serious challenge to a DNACPR position, from whatever quarter, the legal position must be considered. Healthcare professionals, who take a fully-considered ethical and clinical position, should receive support from their organisation.

A close relative, named supporter or main carer might also openly express disagreement with a decision not to provide CPR. In such circumstances, you must respect and listen to the concerns. A review by the team should take place. If the original position of the team is upheld, then a second senior clinical opinion may occasionally be advisable depending on individual circumstances but with the knowledge and consent of the patient. However a relative’s wishes cannot override the agreed position of the patient and the clinical team.
Audit point – 16: DNACPR Case for automatic review – Example 3

It should be considered an “exceptional clinical event” to pursue a DNACPR position that is contrary to the expressed wishes of the patient.

When a patient makes a request for “full CPR” that is clearly contrary to the unanimous judgment of the clinical team, this should be urgently re-considered by the clinical team and an attempt made to reconcile the position. A second senior clinical opinion should be considered. In exceptional circumstances legal advice may be necessary. All such cases should be subject to reflection at a later audit to facilitate team and organisational learning.

8.4 Patients with Implantable Cardioverter Defibrillator Devices (ICDs)

Patients with a DNACPR decision in place who also have an Implantable Cardioverter Defibrillator device (used to treat life threatening arrhythmias) require particular consideration. The decision as to when to deactivate the device requires careful planning and discussion between senior clinical colleagues (with expertise in ICD usage), the patient and those closest to them. In emergency situations teams must consult local policies or discuss with on call experts as to how to temporarily deactivate a device. All processes of informed consent and consultation with patient and close relatives apply to this element of care.

8.5 When clinical care extends between health sectors or across borders

Holistic care spans health and social care sectors with teams working in partnership with patients. Clinical staff from different sectors ideally should, whenever possible, be involved at the beginning of the DNACPR process. Such input and team-working can prove helpful in deciding whether a DNACPR discussion is warranted and can assist future care across boundaries. The General Practitioner and wider primary care team can play a key role in this.

When a patient is receiving out-patient or short-term (day) care across national borders then Local Health Boards in Wales must notify the other providers of the current local DNACPR status of a patient. If outpatient care is delivered outside Wales then teams initiating the clinical referral also have a clinical duty to inform providers of the position in advance of the outpatient or day-care appointment.

For in-patient stays, when patients are cared for outside NHS Wales, patients should have their DNACPR arrangements immediately reviewed in the new health-setting, subject to that provider’s existing arrangements. Such patients will require support from their GP to instigate a review on discharge. For those in non-NHS settings they should be managed within the clinical governance arrangements of their long term placements which should be cognisant of, and ideally aligned to, the principles of this policy.

9. Training on DNACPR and community awareness

A DNACPR training application, emphasising the importance of good communication with patients and those closest to them, should be placed on Local Health Board and Trust intranet systems. It should clearly outline this policy and facilitate access to further DNACPR information. Local Health Board junior doctor and nurse induction programmes across Wales must raise awareness of this policy. Primary care professionals must be offered access to training provided by Local Health Boards. It is vital that evidence is provided that this policy straddles the “whole system of care” and hence all relevant NHS staff therefore should have easy access to knowledge bases, senior clinical support and to the training necessary in order to deliver an effective system for DNACPR. The training needs to ensure awareness of the personal and specific nature of these decisions with awareness of the needs of patients. It is also recommended that those clinicians undertaking senior responsible clinical roles across the NHS in Wales should undertake education on this DNACPR policy as part of their professional appraisal/revalidation cycle.
It is essential that those undertaking roles related to this policy in all community settings have access to practical work based training and education (provided ideally by Resuscitation Officers based within Local Health Boards). Training in such arenas should place some importance on the evidence and basis of knowing when NOT to provide CPR, as well as providing practical training on the performance of CPR. This training relates also to all ambulance staff with responsibility for the provision of CPR. A register should be developed and maintained of those individuals who have received training in DNACPR. Regulatory authorities for Wales should be made aware of this and might consider this as part of their monitoring of standards in community settings.

10. Measurement and Clinical Audit in NHS Wales

10.1 Audit of DNACPR in Wales

This All Wales DNACPR policy may have impact in a number of areas in relation to:

10.1.1 Processes and NHS administration

- Access to (and deployment of) All Wales DNACPR Forms - across all sites
- Communication systems for DNACPR in place across the whole system of care
- Systems for collation of Serious Incidents and/or complaints and/or special reviews related to DNACPR issues (e.g. local mortality reviews, Coroner’s cases) – accessible, with documented learning and with links to professional appraisal
- Staff awareness of the DNACPR policy and access to DNACPR education and training

10.1.2 Clinical and Professional aspects (Audit points 1-16)

- Decision making and appropriate use of NAAD/DNACPR
- Evidence of a correct assessment of mental capacity - when indicated
- Evidence for intention to consider advocacy and a welfare attorney in relation to DNACPR.
- Clinical aspects – appropriately completed and detailed DNACPR form
- Review of clinical communication (with learning events) about DNACPR involving all clinical teams (WAST, Emergency Department, Primary Care, Nursing Home etc.).
- Complex cases logged for shared learning and ongoing policy adjustment at annual national learning event.

10.1.3 Communication and Teamwork

- Understanding responsibilities re: DNACPR roles within clinical teams
- Evidence of appropriate oversight by the Senior Responsible Clinician
- Evidence of MDT team decision making in the DNACPR process
- Evidence of correct communication across sectors including Primary Care, Out-of-Hours and emergency care systems
10.1.4 Privacy, dignity and respect for patients and families

- Evidence of “spot check reviews” that decisions have been approached and reached with due regard for the patient’s dignity and in privacy
- Evidence of processes for special case DNACPR review
- Internal tests of communication, coordination and responsiveness re: DNACPR decision-making

“Whenever possible a DNACPR audit should include patient input” (Dignity revolution).

These elements should form the basis of a local DNACPR audit template. Local Health Boards following DNACPR implementation are expected to assess performance against these headings.

11. References

Nolan J Cardio-respiratory resuscitation BMJ 2012 345: e6122

Death by Indifference - 74 deaths and counting a progress report Pub: Men cap - 2012

“Dignified Care - One year on - The experiences of older people in hospitals in Wales – 2012 – Pub: The Older peoples Commissioner for Wales.


Equality Act (2010)


NHS End of Life Care Programme & the National Council for Palliative Care (2008)

Decisions relating to cardio-respiratory resuscitation: A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2014).

Treatment and Care towards the end of life: good practice in decision making. General Medical Council. (2010)


Time to Intervene: A review of patients who underwent cardio-respiratory resuscitation as a result of in hospital cardiac arrest NCEPOD (2012)
WHILST ACTIVE, THIS FORM MUST BE FILED AT THE FRONT OF THE PATIENT’S HEALTHCARE RECORD

1. Does the patient have capacity to make and communicate decisions about CPR?  
   YES/NO

   If “NO”, are you aware of a valid Lasting Power of Attorney (Health & Welfare) or Advance Decision to refuse treatment (only valid for adults over 18) refusing CPR which is relevant to the current condition?  
   YES/NO

   If “YES” go to Box 6

   If “NO”, has the patient appointed a Health & Welfare Attorney to make decisions on their behalf?  
   YES/NO

   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: Tick all that apply (go to box 3)

   Clinical Summary:

   Reasons:

   Not in the best interest/harm from CPR>benefit  
   This is a natural anticipated and accepted death  
   Patient refused CPR  
   Other (please elaborate in patient’s healthcare record)

3. Has a discussion taken place with the patient, a Health and Welfare Attorney, or IMCA? If CPR has NOT been discussed please clearly record reasons (go to box 4)

   Yes
   No

4. Has appropriate discussion taken place with those close to the patient? (e.g. spouse / partner, family and/or trusted friends, carers, or advocate) (go to box 5)

   Yes
   No

   Name of NOK/Proxy: .............................................................  Relationship to patient: ..........................................................

5. Healthcare Professional completing this form: (Document is ONLY active when signed, timed and dated with GMC no.)

   Name (PRINT): .................................................................  Position: .................................................................

   Contact Details: .............................................................  GMC No: ....................... or NMC No: .......................  
   (nurse – form NOT active unless countersigned in box 6)

   Signature: ........................................................................  Date: ……/……/……/ Time: ……………………………

6. Senior Responsible Clinician with oversight to sign below: (Must inform other team members/teams of the decision – please record overleaf)

   Name (PRINT): .................................................................  Position: .................................................................

   Contact Details: .............................................................  GMC No: .......................  

   Signature: ........................................................................  Date: ……/……/……/ Time: ……………………………

7. CANCELLATION of decision: NB: Cross form CLEARLY and write “CANCELLED” across form – notify ALL copy holders (see details overleaf)

   Name (PRINT): .................................................................  Position: .................................................................

   Contact Details: .............................................................  GMC No: .......................  

   Signature: ........................................................................  Date: ……/……/……/ Time: ……………………………
In the event of a cardiac or respiratory arrest no attempts at cardio-respiratory resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

- The patient’s full name, date of birth and address must be written clearly.
- The date of completing the form must be entered.
- The decision must be communicated to all parties involved in the active care of the patient.
- The patient’s clinical and DNACPR status should undergo routine review of circumstances, by the agreed review date at top of the form.

1. **Capacity / Advance decisions**

If the patient does not have capacity please ensure that an *Assessment of Mental Capacity and Best Interests Decision* form is completed. Ensure that any Advance Decision is specific and valid and applicable to the patient’s current circumstances. Legal advice can be considered in the event of disagreements, as recommended in the All Wales policy.

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

Please be as specific as possible. More detailed information can be recorded in the patient’s healthcare record.

3. **Summary of communication with patient**

State clearly what was discussed and agreed. If the decision was NOT discussed with the patient clearly state the reason why. If an interpreter is used they must be approved by the organisation.

4. **Summary of discussion with those close to the patient (e.g. spouse/partner, family and trusted friends, carer, or advocate)**

If the patient does not have capacity those close to the patient must be consulted and may be able to help by indicating the patient’s recent wishes. They cannot make the decision to withhold cardio-respiratory resuscitation - this is a medical decision. If the patient has made a Lasting Power of Attorney for Health & Welfare (ensure that it is registered) or patient has appointed a Health & Welfare Attorney to make decisions on their behalf, that person must be consulted. A Health & Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity - ensure that discussion with others is with their consent and does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes.

5. **Health professional completing this DNACPR form**

This will vary according to circumstances and local arrangements. This should be a senior professional when available. The form becomes active when a medical professional signs, times and dates the form and provides their GMC number.

The decision must be overseen by the senior responsible clinician (usually the patient’s Consultant or General Practitioner) at the earliest opportunity. If the senior responsible clinician is NOT the doctor initially completing the form, they must be informed as soon as reasonably possible. If a review of circumstances around the DNACPR form is necessary, this should be undertaken in line with the all Wales policy. Any review of the decision is subject to communication requirements as outlined in All Wales policy.

6. **Details of the senior responsible clinician involved in the decision**

Ensure all details (name and position) are completed (see All Wales policy) and that the DNACPR decision is communicated to all those involved in the patient’s care as in All Wales policy.

7. **Cancellation of the Decision**

Ensure all details are completed. The form should be crossed through diagonally using 2 lines and “CANCELLED” should be written clearly between them, and signed and dated by the doctor cancelling the decision. The cancelled form must be filed within the current clinical record and this should be communicated to all copy holders below - as per All Wales policy.

COPIES of this DNACPR decision form have been sent to:

1. 
2. 
3. 
4. 
5.
List of key contributors to this policy:

(Chair) Dr Paul Buss Assistant Medical Director – Aneurin Bevan Local Health Board

Baroness Ilora Finlay, Professor of Palliative Medicine, Consultant in Palliative Care, Velindre NHS Trust, Chair of the All Party Parliamentary Group on Dying Well

Professor John Saunders, Consultant Physician, Aneurin Bevan Health Board, Chair of Royal College of Physicians Ethic Committee

Professor Rob George, Consultant in Palliative Care Medicine, Guys & St Thomas Hospitals, Clinical Lead for Palliative & EoL Care for London, Hon Secretary to the RCP Committee on Ethical Issues in Medicine, Professor of Palliative Care Cicely Saunders Institute, King's Health Partners

Professor Vivienne Harpwood, Vice Chair, Cwm Taf HB, Professor of Healthcare Law

Dr Ian Back, Consultant in Palliative Medicine, Cwm Taf Health Board

Dr Idris Baker, Consultant Palliative Care ABMU Local Health Board

Dr Rupert Evans, Consultant Emergency Medicine, Cardiff and Vale Local Health Board

Dr Charlotte Jones, Deputy Chair GPC Wales

Carol Shillabeer, Nursing Director, Powys Local Health Board

Jane Dale Assistant Director, Patient Safety Aneurin Bevan Health Board

Tim Heywood, 1000 Lives Programme, NLIAH

Tracey Good, Senior Equality Manager, NHS CEHR

Mr John Tobin, Senior Lead for Resuscitation, BCUHB

Mrs Rachel Kemp, Care Forum Wales

Resuscitation officers across NHS Wales and Health Board leads

Clinical stakeholders attending meetings in North, West and South East Wales

Stakeholders attending stakeholder events and meetings across Wales

Contributions from the process of public engagement

Legal support from NWSSP Legal and Risk
1. Introduction

The Equality Act 2010 places a positive duty on public authorities to promote equality for nine protected characteristics* and requires Welsh public bodies to demonstrate how they pay ‘due regard’ to equality when carrying out their functions and activities. In the context of this work, health boards and NHS Trusts are required to assess the impact of policies and services on equality and human rights. The purpose of this is to ensure that as far as practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

2. Policy Aims and Context

Cardiopulmonary resuscitation (CPR) of patients can be an important, life-sustaining intervention. ‘It was originally developed to save the lives of younger people dying unexpectedly, mostly from primary cardiac disease. However, CPR has come to be seen as a procedure that should be used for patients as a therapy to restore cardiopulmonary function and prolong life, irrespective of the underlying cause of cardiac arrest’. (1)

The purpose of this policy is to provide a policy framework for professionals and NHS bodies in Wales in order to enable a consistent approach to decisions relating to the provision of CPR. Whilst for every individual, death is inevitable, achieving a dignified, sensitive and shared approach to reaching a decision relating to CPR is vital for patients and those who are close to them.

* Race; Sex; Gender Re-assignment; Disability; Religion, belief/non belief; Sexual orientation; Age; Pregnancy and maternity and Marriage and civil partnerships
The decision not to attempt CPR on a patient is a major clinical decision. The aim of this policy is to help achieve a position where a discussion about CPR is accorded the highest level of significance. This should help develop across NHS Wales the correct approach of consistent planning of care with regard to CPR as a treatment option and an approach that is centred on an individual plan for each patient where any decision not to attempt CPR is based on an informed and proper discussion with the patient and those who are close to them.

A core group was established in January 2012 to develop a unified policy framework that would promote high standards of decision making in all care settings and a person centred approach that ensures the highest standards of clinical care and treatment.

The approach to developing the DNA (Do Not Attempt) CPR Policy has been grounded in the public sector equality duty principles of evidence; transparency; engagement and leadership to ensure that it impacts in a fair and positive way. Members of the core group are drawn from clinicians involved in palliative, intensive and emergency care, resuscitation officers, quality and patient safety managers, representatives from primary care and the independent care sector, community health councils, the General Practitioner Committee, Wales, ethics and equality and human rights. The design of the framework has taken account of best practice from other parts of the UK including the learning from South Central England and Scotland. A leading expert from Guy’s Hospital in London has supported the work in an advisory capacity.

Early engagement with a wide range of clinical stakeholders was undertaken with three regional clinical workshops held between October and December 2012. These workshops considered key principles and case studies to test different patient scenarios in a range of clinical and non clinical settings.

Non clinical stakeholders have been key partners in this work and two engagement events were held on 13th September 2012 and 29th January 2013. Separate and focused engagement has also taken place with Mencap Cymru and the Older People’s Commission to gain a better understanding of the issues for people with learning disabilities and older people.
Key principles and issues raised by DNACPR have been explored from a broad range of clinical perspectives and also, from the individual patient and family/carer’s perspectives. Participation from a range of third sector organisations has raised awareness and understanding of the different and diverse needs of people living in Wales. The draft Policy is the product of this wide engagement.

3. **Available Research Evidence: Literature Review**

A literature review was carried out as the first stage of the process of gathering evidence to inform this equality impact assessment. The results of the literature review are provided below against each of the protected characteristics. There is some research evidence that has specifically highlighted the particular issue of DNACPR in relation to people with protected characteristics. Broader and more extensive research concerned with understanding the needs and experiences of patients when they require end of life care has also been considered, where relevant to DNACPR.

**Age**

Demographic evidence demonstrates that people are living longer. By 2005-09 life expectancy in Wales had increased to 77.0 years for males and 81.4 for females. Population projections published by Public Health Wales suggest that the number of persons aged 15-24 will decrease by 4% in 2031 whereas an increase of 79% is forecast for the 75+ age group.

Population age structures in rural areas are older and often this is compounded by outward migration of younger people and inward migration of older people. Current projections indicate that the increase in the proportion of older people will be greater in rural areas. As well as having an older age structure, the population in rural areas is by definition more dispersed leading to difficulties in respect of access to, or the provision of, services. (2)
The Public Health Wales Observatory has reported that although life expectancy overall has increased, inequalities in both life expectancy and quality of life in Wales have persisted if not slightly increased. Life expectancy has increased more slowly in the most deprived areas compared to the least deprived in Wales. The gap between the most and least deprived areas is 18.9 years for males and 17.8 years for females. This contrasts with the national inequality gap in life expectancy overall of 9.2 years for males and 7.1 years for females. (3)

Older persons are disproportionately affected by chronic conditions. The Welsh Health Survey reported that 82% of respondents aged 65 years and over suffered from a chronic condition, of whom 54% suffered from two or more. If current trends continue the number of people living with chronic conditions will continue to increase in the future, with people living longer and developing more than one chronic condition. (2)

Research undertaken by the National Confidential Enquiry into Patient Outcome and Death (2102) (1) assessed the case notes of 586 adult patients who had a cardiac arrest, triggering either a call to the resuscitation team that led to the delivery of chest compressions or defibrillation during a 14 day study period in 2010. The median age for the sample included was 77 years.

With an increasingly ageing population it will be important to ensure that DNACPR decisions are not adversely affected by negative attitudes towards older people and negative assumptions about their quality of life.

Research published by the Older People’s Commissioner for Wales in 2011 (4) highlighted the findings of Dignity and Essential Care Inspections carried out by Healthcare Inspectorate Wales. Do Not Attempt Resuscitation (DNAR) forms not always being fully completed and up to date was reported as a constant theme and challenge. The Research refers to ‘clear, effective communication (as) essential to help older people exercise choice and control in a healthcare setting.
A lack of information and advice about health conditions, medical treatment, or the quality of care an older person should expect can cause fear and uncertainty and make a stay in hospital more difficult. (4)

The ‘Together for Health – Delivering End of Life Care’ Delivery Plan sets out the Welsh Government’s expectations of NHS Wales, ‘working with its partners, in particular the hospice and social care sector, to reduce inequalities in end of life care up to 2016. It sets out how patients and their families will be supported at the end of life, providing high quality care in all settings for people of all ages’. (5)

Disability

People with Learning Disabilities

Research by the former Disability Rights Commission (DRC) in 2006 (6) found that people with learning disabilities are more likely to die young and to live with physical ill health than other citizens. The research found that people with learning disabilities are more likely to be obese, and to experience chronic and long term health conditions, such as respiratory disease and Diabetes. They are also more likely to be diagnosed with these conditions at a younger age than the general population.

The research identified a range of causes to explain the physical health inequalities including poverty, difficulties recognising symptoms, lack of access to healthy lifestyles, inequalities in access to screening and treatment and the side effects of medication. One of the most significant barriers to healthcare was identified as the perceived negative or discriminatory attitudes of healthcare staff.

Many respondents in the research felt that their physical health or other health needs were neglected, or more readily dismissed, due to their learning disability. This was referred to in the research as ‘diagnostic overshadowing’, attributing any physical symptom to an underlying mental health problem or learning disability.
Research published by Mencap in 2012 (7) highlights how discriminatory and negative attitudes towards people with learning disabilities and their quality of life have adversely influenced DNACPR decisions; ‘the doctor took one look at my son and said that he was not for resuscitation’. In another example, healthcare professionals are criticized for making ‘discriminatory and incorrect assumptions’ about people with learning disabilities following a ‘do not resuscitate order. In this instance the reasons given on the CPR form were listed as ‘Down’s syndrome, unable to swallow ... bed bound, learning difficulties’.

Mencap’s research (7) highlights that ‘the inappropriate use of DNR orders has remained a constant feature of many Mencap cases. There have been circumstances where DNR notices have been applied without the knowledge or agreement of families and applied hastily in inappropriate situations, solely on the basis of the person’s learning disability’.

Mencap’s research (7) also suggests that healthcare professionals are often unaware of issues around capacity and consent to the extent that patients are often denied treatment or treatment is delayed. This is referred to as ‘flawed best interest decision-making’ when, despite the process being technically followed, the medical advice given in the best interest decision meeting has been weighted in favour of a decision not to proceed with active treatment and the application of DNR orders. This has led to families sometimes agreeing with the decision, only later to find that there was a better prospect of recovery with treatment than they had been told.

Mencap refer to many accounts from families of treatment not being given under the guise of concern about consent. This raises the important need to properly apply the law on consent which is clear that if a person lacks capacity to consent to treatment, a decision must be made on their behalf in their best interests, and the family should be involved in this decision.
People with Sensory Loss

There is a plethora of research published by sensory loss organisations to evidence the barriers to communication experienced by people with sensory loss when they need to access healthcare. These experiences extend to family and carers with different communication needs who should be involved in the DNR decision making process.

Recent research into the experiences of Deaf people (8) when they need primary and secondary healthcare highlighted that 27 out of 36 people who had recently experienced staying in hospital, were not provided with the services of a British Sign Language interpreter when being asked to sign a consent form. Respondents in this research stated that they often missed information and did not fully understand what the doctor was saying.

There could be a potential negative impact for people with sensory loss if their different communication needs are not recognised and met.

People with chronic and long term health conditions

The Welsh Government has quantified the extent of chronic conditions on the population in Wales. (2) One third of adults in Wales (an estimated 800,000) reported having at least one chronic condition; of people aged over 65 in Wales, two thirds reported having at least one chronic condition, and one third had multiple chronic conditions; and over three-quarters of people aged over 85 in Wales reported having a limiting long-term illness. If current trends continue, the number of people living with chronic conditions will increase with people living longer and developing more than one chronic condition.

A study looking at the palliative care needs of people with chronic obstructive pulmonary disease (COPD) (9), concluded that few people with end-stage COPD are given an opportunity to make decisions about their end of life care and despite the majority saying that they would wish to die at home, the majority are still dying in hospital.
People with Mental Health Conditions

Research in 2006 (6) found that people with mental health conditions experience poorer physical health than the general population. It highlighted that people with mental health conditions are more likely to experience chronic and long term conditions, for example, respiratory illnesses, Diabetes, heart disease and cancer.

Informed consent is an important issue for patients with mental health conditions. The statutory framework on capacity and consent issues is set out within the Mental Health Capacity Act (2005). This must be fully taken into account in any DNACPR decision making process.

Race

Census data shows that in 2011 more than nine out of ten (93.2%) residents in Wales were White British while 6.8% of the population (208,006) were from Black Minority Ethnic (BME) groups. A comparison of census data from 2001 and 2011 demonstrates that the population in Wales has increased across all BME groups with the exception of White Irish.

In the context of age, most of the population aged 65+ is White British. Data also shows that most ethnic groups have been ageing since mid 2001 (exceptions are Mixed White and Black Caribbean and Other Black). Amongst the BME groups, Indian (over one thousand people), Pakistani (almost one thousand people) and Black Caribbean (around 700 people) populations have the highest number of people aged 65+. Recent UK wide population projections identify that ageing trends are expected to continue. By 2026 it is estimated that there will be over 1.3 million people in the UK from BME groups aged 65+, many of whom may experience life limiting illnesses.

In the context of languages spoken, in 2011 97.1% of the population in Wales spoke English or Welsh as their first language. The second most spoken language was Polish (0.6% or 17,001). This was followed by Arabic (6,800), Bengali (5,207) and Tagalog/Filipino (2,749).
The majority of people who do not speak English as a first language could either speak it well or very well, whereas 19,305 people whose main language was not English, could not speak English well or at all.

A number of studies in England have looked at the needs of both Black and Minority Ethnic patients and carers in end of life care and have found that there are factors associated with culture and language which need to be considered to fully meet their needs (10).

**Religion and belief**

More than half of the population in Wales (57.6%) described themselves as Christian in 2011 whilst almost a third reported having no religion. The second most reported religion was Muslim, which represented 1.5% (45,950) of the population.

There is evidence from research undertaken in England (11) that ethnic and cultural differences can influence patterns of advanced diseases, illness experiences, healthcare seeking behaviour and the use of healthcare services. The values and beliefs that underpin religious traditions and family roles might also be seen as incompatible with palliative/hospice care. Some groups might avoid disclosing prognosis and diagnosis in order to protect the patient or avoid distress. (11).

Most of the evidence on disparities and unmet needs for BME populations when in receipt of palliative and end of life care refers to poor communication between healthcare professionals and the patient/family. ‘Moreover, these interactions rely heavily on high quality communication between health and social care professionals and patients and their families. The inability to engage in communication not only affects access to palliative care services but has been shown to be a source of serious problems in clinical consultations and the cause of misunderstandings amongst patients, family members and healthcare providers’. (11)
Poor communication has been identified as a serious problem when providing care to BME groups. ‘This is associated with a lack of sensitivity to cultural and religious issues (and consequent poor understanding of needs) and lack of translation resources. It is also highlighted that poor communication can ‘impede a doctor’s ability to assess the patient’s mental competence to make informed decisions’ (11).

The evidence has also highlighted differences regarding end of life decisions (such as a lower use of advance care planning documents and more choices of aggressive treatment (13). Substantial evidence reports that minority ethnic groups are less likely to complete advance directives than the majority White. ‘They are more likely to desire life-sustaining treatment and aggressive treatments such as artificial nutrition and cardiopulmonary resuscitation even where there is no hope for recovery’.

Reasons for these differences are complex and sometimes contradictory. The most commonly discussed issues were mistrust regarding the healthcare system, the importance of religion and difficulties in trying to apply the Western model of autonomy to different cultures. It seems to affect both decisions to undertake aggressive treatments and decisions not to use advance care planning. (11)

Religion has a fundamental influence in shaping treatment decisions at the end of life. ...The idea of autonomy, right to self determination and control over dying is not a universal value and it is not shared in all parts of the world. Many patients might prefer involvement in decision making by families and health professionals. The concept of advance care planning documents is not universally accepted and might be seen as an ‘intrusive legal mechanism’ interfering with the family responsibility to care for their loved ones, a violation of one’s self identity and family. (11)

In some cultures where the patient is protected from hearing their diagnosis while the family receives the information, discussing advance care planning might actually harm patients and their families’ (11).
The research evidence highlights that religion has a fundamental influence in shaping treatment decisions and this must be understood and respected by healthcare professionals when they need to consider advanced care planning and the application of CPR.

Sex

There is evidence to demonstrate that there is a gender difference in life expectancy and women in Wales can expect to live 4.4 years longer than men. Females are, however, estimated to spend only around two years longer than males in good health or free from limiting long-term illness or disability. (3)

There is no research evidence to suggest that there are particular issues that need highlighting in relation to DNACPR.

Sexual Orientation

Research identifies a number of key issues for LGB people: professional staff attitudes towards sexual identities influences the quality of care offered and received and that heterosexual assumptions may exist throughout care (12).

Consultation for the English End of Life Care Strategy Equality Impact Assessment noted that in terms of quality of end of life care, Lesbian, Gay and Bisexual (LGB) people were most at risk of discrimination (12).

Guidance produced by the Royal College of Nursing and UNISON (Not ‘just’ a friend: best practice guidance on healthcare for lesbian, gay and bisexual service users and their families) suggests that it can be a concern for LGB people that someone close to them will be denied visiting rights and information because they are not seen as the ‘next of kin’. Guidance was published by the Welsh Assembly Government in 2008 to raise awareness of the needs and rights of lesbian, gay and bisexual people when accessing healthcare services in Wales (13).

The guidance highlights that recognition of next of kin/nominated contact when one partner is in hospital or needs medical treatment is an issue of great concern to same-sex partners.
Although there is no legal definition of ‘next of kin’ in this context, and nothing to prevent same-sex partners acting as ‘next of kin’/nominated contact in these circumstances, there are still misconceptions about this among the general public and among medical and other staff. Confusion arises over who is ‘next of kin’ because the general understanding of the term is that it is a blood relative or married or civil partner. However, this is not the case and lesbian and gay couples who have not registered a civil partnership and unmarried heterosexual couples can, if they so wish, nominate their partner as ‘next of kin’. (13)

The DNACPR Framework will need to ensure that it is inclusive of and recognises the rights of same-sex families. Medical and other staff should be supported to challenge prejudiced attitudes and behaviour in staff and other service users and need to be aware of the impact on privacy and confidentiality. The important need to recognise the diverse identities of patients and to be sensitive to their choice of ‘next of kin’ was raised throughout the engagement work.

Older lesbian, gay or bisexual people represent a generation who lived in times when same sex relationships were pathologised and, for gay and bisexual men, illegal. This group may have experienced incidences of prejudice and therefore be less open than younger generations. (12)

Research suggests that it is likely that older LGB people will anticipate or have had experience of negative reactions relating to their sexual orientation or gender identity. This can impact on the person’s ability to have discussions about end of life care and access to local community support.

Previous disclosure of sexual orientation may have been traumatic. For some it could also lead to a distancing from families of origin such that the individual may rely on and prefer alternative networks of support. However, there is a risk that the significance of ‘friend’ relationships is not recognised before and after death. This could result in a person or group, their relationship with the dying person and their grief going unrecognised. (12)
Gender Re-assignment

The above research considered in the context of Lesbian, Gay and Bisexual people also included the experiences of Transgendered people. Many of the issues highlighted above will be as relevant to Transgendered people.

Welsh Language

Public services have a responsibility to comply with the new Welsh Language (Wales) Measure. This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. Meeting the information and communication needs of patients who speak Welsh will need to be taken into account in the DNACPR decision making process.

‘Language is at the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual, is an essential principle of maintaining dignity and respect in care within a bilingual setting’. (14)

Language provision is particularly important for older people who may only be able to communicate using their first language when they become unwell. The Strategic Framework for Welsh Language Services in Health, Social Services and Social Care, ‘More than just words …’ refers to older people in residential care settings discovering ‘that their ‘sense of self’ and ‘social recognition’ diminishes because their body and mind is deteriorating. Some will have already suffered losses such as bereavement, their home, and some physical and mental skills. It’s essential therefore to provide care that reflects a person’s language and cultural background in order to respect their identity and maintain their dignity’. (14) In addition to older people, the Welsh Government has identified three other priority groups where Welsh language services are especially important, these are: children and young people; people with learning disabilities and people with mental health problems. These groups are particularly vulnerable because their care and treatment suffers when they are not treated in their own language.
Human Rights

A CPR decision is highly relevant to the Human Rights Act 1998 and in particular, the right to life (Article 2), the right not to be tortured or treated in an inhuman or degrading way (Article 3) and the right to respect for private and family life, home and correspondence (Article 8).

Clinical decisions about whether or not to attempt CPR often arise in difficult circumstances. Rates of survival and complete physiological recovery following in-hospital cardiac arrest are poor. A high proportion of in-hospital deaths now involve CPR attempts, even when the underlying condition and general health of the patient makes success very unlikely. This can mean that patients may undergo futile attempts at CPR during their dying process. Effective Do Not Attempt (DNA) CPR decision making should improve patient care and prevent futile and undignified procedures at the end of life.

Research published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2012) revealed the need for a closer definition of the aims of the treatment of sick people in hospitals and raises many issues including the disparity between the public and professional perception of the outcome of CPR, effective communication and informed consent and ensuring a dignified death.

There are times when cardiopulmonary resuscitation (CPR) is inappropriate. It may be futile because a patient is dying from a terminal illness or it may be against the wishes of the patient. A decision making process that allows healthcare professionals to be informed when CPR should not be initiated, is central to person centred care and enabling a dignified death for patients and compassion for their families and carers who would want their loved one’s wishes to be fulfilled.

Placing DNR notices on a patient’s record without their knowledge or consent or that of their family members is likely to constitute a breach of human rights and in particular, Article 8 which safeguards respect for patients’ private lives.
The Equality and Human Rights Commission intervened in a Court of Appeal case which revolved around whether seriously ill patients and their loved ones have the right to be consulted about the use of DNR Notices. The Court of Appeal has ruled that doctors have a legal duty to consult with and inform patients if they want to place a DNR order on medical notes.

Historically, blanket policies that are based on subjective factors such as age and quality of life may also have a discriminatory impact and could be subject to a human rights challenge.

4. Themes from Engagement

The third sector organisations that have been involved in the DNACPR engagement work are listed on Appendix 1. The key themes that were highlighted through engagement are:

- The important need to ensure that patients and carers/families are fully involved in the DNACPR decision making process.

- The need to ensure that the appropriate next of kin is recognised in the care and treatment of an individual.

- The need for effective, accessible and kind and sensitive communication and information to ensure that DNACPR is explained and understood. Good communication is at the heart of this. It is about communication between families and not just professionals. People knowing what their loved one would want.

- The need to ensure that DNACPR decisions are recorded and transferred across and between primary, community, secondary and independent care sector organisations.

- The need to promote a non judgemental and positive attitude towards disabled and older people to ensure that DNACPR decisions are not based on unlawful discriminatory attitudes and stereotypes.

- The need to inform and change public perceptions of CPR and the limits of its effectiveness.
• The need to address the risk of creating negative perceptions of DNACPR decisions as a withdrawal of any further treatment and care.

• Mental health is not the same as mental capacity. It is important to recognise symptoms and their impact on mental capacity. The timing of conversations to explore an individual’s wishes is important in this respect. A decision may reflect the way the person is feeling at that particular time.

• Part of the Policy should be about who has the conversation – senior medical staff, the person who knows the patient, their illness and prognosis.

• Faith, culture and end of life.

• Welsh Language and other language provision.

• This is not just about older people. It is about everyone.

• The role and involvement of carers and people without carers/family or estranged families and homeless people – the role of independent advocacy.

• People receiving healthcare outside of Wales, for example, prisoners in England and people with severe mental illness – cross border issues.

• Family/carer support and the issue of guilt.

• The need for simple information for all ages.

• The application of electronic record systems and processes for information travelling with patient. How will the Policy work in emergency situations and how will information transfer between primary, secondary, community and independent care settings.

• How will accountability be addressed within the Policy Framework, including how you ensure that everyone is
responsible for implementing the Framework, that staff are familiar with and have been trained in the process and the standards expected as well as receiving training in communication skills, plus the need to understand that they will be held to account for their actions.

- How will the Policy Framework be monitored and will the process be self assessment. If this is the proposed tool for the framework, it might be helpful to acknowledge that this might not give a true assessment of the situation. Self assessment can be successful where there is a genuine desire to improve but it can also have the potential to mask poor performance when there is denial that improvement is needed. An example of this is the Mid Staffs Healthcare Commission report which showed that the hospital was functioning well, whilst in actual fact it was failing.

There could be cross referencing the results with complaints received/concerns raised in relation to DNR decisions, HIW and Ombudsman complaints/investigations, etc. It might be useful to look at other all Wales Frameworks that have been introduced, eg nutrition/medicines, to assess the effectiveness of the monitoring tool and any improvements to enhance it.

It might be useful to consider whether an external assessment could help with raising the credibility of the audit process. Patient stories could be used in conjunction with other methods, for example, inviting people who have used the service to work alongside professionals. This could include involving people in staff interviews and induction, audit meetings, research, resolving complaints, concerns, etc.

The main themes highlighted are that communication has to be at the core of the policy and practice; that DNR decisions must be grounded in person centred care that acknowledges and responds to the diverse needs and identities of patients and that robust and transparent monitoring arrangements are developed and implemented that are capable of evidencing that the Policy is being delivered effectively.
5. **Outcomes**

Equality impact assessment is a continuous process. The assessment has so far demonstrated that DNACPR is relevant to all of the protected characteristics and that there are particular issues to consider with regard to age, disability, race, sexual orientation and human rights. Research has evidenced that there is the potential for DNACPR decisions to impact adversely on disabled and older people. This will need to be monitored as part of the implementation of the policy at a local level to ensure that there is no negative impact.

There is a lack of research specific to Wales to highlight the issues and/or experiences of Lesbian, Gay, Bisexual and Transgendered people, older Black Minority Ethnic (BME) groups and different faith groups. Focused engagement with these groups at a national and local level should be explored as the Policy is further developed and monitored.

The important need to involve carers and people who are close to the patient in the DNACPR decision making process is recognised within the policy framework. Developing awareness of the Policy with carers and organisations that represent them should help to ensure that the aims of the Policy in this respect are achieved.

April 2014
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14. More than just words ... Strategic Framework for Welsh Language Services in Health, Social Services and Social Care (2012)
Appendix 1

A Dignified Revolution
Age Cymru
Diverse Cymru
Gofal Cymru
Marie Curie
Mencap Cymru
Older People’s Commission
Transgendered Wales
“Sharing and Involving”

Information for patients and their carers to help make decisions about CPR (Cardiopulmonary Resuscitation)

Issue date: October 2014

This leaflet tells you and those close to you what CPR is and how decisions about CPR are made. It may not answer all of your questions so please speak to your healthcare team about anything you do not understand.
What is CPR?

CPR is an emergency intervention that tries to restart your heart and breathing if they stop. This can be a medical emergency but for many it is a natural process at the end of life. CPR is a separate and different intervention to the treatment that you are already receiving.

CPR may include:

- Repeatedly pushing down firmly on your chest.
- Using a special mask or a tube to help you breathe.
- Using electric currents from a defibrillator to try and restart your heart.
- Using medication, often given into the veins, in order to help restart your heart.

Talking about CPR

Depending on the healthcare setting and your health a GP, hospital doctor, or senior nurse may wish to discuss your wishes around CPR. They will help you to reach a decision.

What if I don’t want to talk about CPR right now?

- You don’t have to talk about CPR if you don’t want to. If you feel you’re not ready to talk about it - just say.

- You may wish to talk about CPR with your family, close friends or carers. They may be able to help you make a decision you are comfortable with.

- Although this may be difficult, please discuss CPR with your healthcare team as soon as you feel able to. This will make certain that your healthcare team fully understand your wishes.

If you are ready to think about CPR please read on. Otherwise please keep this leaflet safe so that you can read it when you are ready.
Who decides about CPR?

You and your healthcare team can discuss if you would be likely to benefit from CPR. They will want to know what you think. Your wishes are very important in making this decision. Unless there are exceptional clinical reasons they will discuss this with you and the DNACPR form will be kept with your health records.

*If you want to, you can talk to the healthcare team looking after you about CPR. Together you can talk about:*

- Your wishes and beliefs.
- Your current health.
- Whether CPR is likely to restart your breathing and heart, and for how long.
- Also whether CPR will help you live longer in a way you can enjoy.
- Also what effect CPR might have on your future health and the way you enjoy life.

They will write the decision, as a result of this discussion, in your notes on a form called ‘Do Not Attempt Cardiopulmonary Resuscitation’ (a DNACPR form).

Will CPR work for me?

CPR does not always work and will depend on:

- Why your heart and breathing has stopped
- What illnesses or medical problems you have (or have had in the past)
- Your general health
Does everyone get back to normal after CPR?

Sadly most people do not survive after a cardiac arrest. Those with complex medical problems are much less likely to make a full recovery. It is important that you know that:

- Patients are often critically unwell after CPR and may need more treatment in a coronary care or intensive care unit
- Most patients do not return to the physical or mental health they had before they had CPR. Some may need a lot of rehabilitation.
- Unfortunately some patients go into a coma from which they might not recover or might suffer from brain damage.

Is CPR tried on everyone whose heart and breathing stop?

If you are seriously ill and near the end of your life, there may be no benefit in trying to resuscitate you as the heart and breathing will stop as a natural part of dying. In these cases, it is more important to keep you pain-free, comfortable and supported. CPR may offer false hope and do more harm than good by not allowing you to die a natural death.

- If your heart and breathing stops unexpectedly, for example if you have a serious injury or heart attack, unless you and your healthcare team have already put a DNACPR order in place the healthcare team will try CPR if they think there is a chance of recovery.
- If your breathing and heart stop before you have made a decision on CPR, the doctors looking after you will decide whether to try CPR. They will take account your general health, things you may have already discussed with them, the views of those closest to you and also how likely it is that CPR will succeed.
Who makes the decisions if I can’t?

If you are unable to understand the information you are given about CPR and cannot make the decision for yourself someone else may be able to decide for you.

For patients unable to make a decision because of illness or a learning disability a person (a legal proxy) can be appointed to make a decision on your behalf to help decide for you. A legal proxy can be:

- Someone you appointed as your Lasting Power of Attorney (LPA) for Health and Welfare or
- Someone a court has appointed to be your welfare guardian, or
- Someone a court has appointed by an intervention order to make a one-off decision (about CPR).

The doctor will always talk through the decision with the legal proxy if this is possible.

- Although your family and friends are not allowed to decide for you, unless they have been given this authority in the form of an LPA, your healthcare team will talk to them to understand your wishes and beliefs.

- If there are people you do or do not want to be asked about your care, you should let your healthcare team know as soon as possible.

What should I do if I know that I don’t want CPR?

- If you don’t want anyone to try CPR, tell your healthcare team. They must follow your wishes.

- Consider telling those close to you your wishes, so they can tell your healthcare team what you want if they are asked.

- You can make an advance decision putting your wishes in writing. If you have an advance decision, please make sure your healthcare team know about it so that they place a copy of it in your health records.

If you change your mind you should tell the Senior Doctor or Nurse as soon as possible.
What if I want CPR, but my doctor says it won’t work?

When you discuss CPR your doctor may say that CPR would not work for you.

- No doctor will refuse your wish for CPR if there is a fair chance that it can be effective.
- If your healthcare team feel CPR will not work for you, you can ask them to arrange a second medical opinion if you would like one.
- If it is thought that CPR is likely to leave you severely ill or disabled, your opinion about whether these chances are worth taking is very important. Your healthcare team must listen to your opinions and to anybody you want to involve in the discussion.
- You and those closest to you should be aware that there is no legal right to demand any treatment that will not work.

When a decision not to try CPR has been made?

If you have decided you do not wish CPR to be tried, or if your doctor is sure CPR will not work, this will be written on a form called ‘Do Not Attempt Cardiopulmonary Resuscitation’ (a DNACPR form). This will be kept with your health records.

This decision is about CPR only. You will get any other treatment that you need, to keep you as well and comfortable as possible.

Your healthcare team will continue to give you the best care and treatment according to your individual needs.

What if I am at home?

Many patients who are dying want to die at home. Even if people close to you know that you do not wish CPR to be tried, they may feel the need to call an ambulance if they become worried about you.

If the ambulance crew or health professionals are informed you have a DNACPR form at home, they must respect your wishes. They will make you as comfortable as possible and arrange further care. They will not try CPR.
What happens if I am discharged from hospital?

To help ensure that other health professionals know your wishes:

- The hospital team will inform the ambulance crew of your wishes
- Your healthcare team will give you a copy of the DNACPR form to take home.
- Please tell people close to you where you keep your DNACPR form should you need to be seen by clinical teams urgently in the future.

If my situation changes or I change my mind?

If your health situation changes your healthcare team will review the decision about CPR. You can also request a review if you change your mind about your decision. Feel free to discuss your feelings with the doctors or nurses looking after you.

Can I see what’s written about CPR?

You have a legal right to see and have copies of your records

You can see what’s written about CPR in your health record. Your healthcare team will have noted what you have said about CPR, and will record any decisions made along with you, in your health records. Your healthcare team should explain any words you don’t understand.

Who else can I talk to about this?

- Any member of staff involved in your care,
- Those closest to you,
- Patient support organisations – for example Macmillan Cancer Support www.macmillan.org.uk or Age UK www.ageuk.org.uk/cymru,
- The hospital chaplain,
- Your own spiritual adviser,
- Independent advocacy services. An advocacy service can help you express your views or make your own decisions, or can speak on your behalf.
How can I find out more?

For more information about anything in this leaflet, please contact:

- A member of NHS staff involved in your care
- The NHS helpline on .................
- (Text phone..........................) or
- Your local citizens advice bureau (find your nearest bureau online at [http://www.adviceguide.org.uk/wales.htm](http://www.adviceguide.org.uk/wales.htm) or in your local phone book.

For more information about advocacy and to find a local advocacy group, contact:

..............................
Phone .................
Website......................

For more information about legal proxies contact:

The Office of the Public Guardian (Wales)
Phone..........................
E mail ..........................
Website......................

For more information about making a complaint, you can get a copy of the leaflet *Putting Things Right: Raising a Concern about the NHS* from:

- Someone in your healthcare team
- The NHS helpline on ..............
  (Text phone.........................)
- Website www.puttingthingsright.wales.nhs.uk
- Your local citizens’ advice bureau (find the nearest bureau on the internet at [http://www.adviceguide.org.uk/wales.htm](http://www.adviceguide.org.uk/wales.htm) or in your local phone book).

This information was developed by the All Wales DNACPR Group and produced after consultation with relevant stakeholders. It is available on all NHS Health Board websites. You can ask someone in your healthcare team for a copy.
Quick Reference Guide

“Sharing and Involving”

A Clinical Policy For DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FOR ADULTS IN WALES

Issue date: October 2014
**Introduction to DNACPR**

This document is a summary of the key elements contained within the policy. A patient information leaflet is provided for patients and those close to them to explain the reasons for the policy.

One aim of this DNACPR policy is to help raise awareness of the importance of discussions that relate to wishes at the end of life. It will help us develop the correct, personal approach, with respect to DNACPR.

The purpose of this policy is to provide a unified framework for professionals in Wales - helping to ensure a uniform approach to decisions relating to the provision of CPR at the end of life.

DNACPR discussions can be difficult and should be conducted in a calm, professional and reflective manner. DNACPR decisions should always involve senior professionals. DNACPR decisions should be recorded on an All Wales form that will be recognised across health sectors in Wales.

Throughout the policy “DNACPR” refers solely to the provision of Cardio-Pulmonary Resuscitation and not to any other aspect of the individual’s care or treatment options.

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**CPR – Cardiopulmonary Resuscitation**

CPR is a technique used to maintain the body's circulation and breathing. It usually means “pressing the chest” and providing ventilation to the lungs. In some cases “defibrillation” using electric shocks and also intravenous injections of medication may be used.

**DNACPR**

This refers to a specific decision NOT to provide CPR in the event of a cardiac arrest. It must be made clear to all that a DNACPR decision does NOT impact on any other element of care.

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**Having the discussion and reaching a decision**

For professionals - recognising when to “consider DNACPR” may not always be straightforward. Quite often “envisaging the possibility of a cardiac arrest or death” in light of the current illness forms its basis. Knowing the wishes of the patient is very important and making DNACPR decisions before a patient becomes too unwell is good practice. This requires members of the medical and nursing team to establish a bond of trust reaching a shared position with patient and involving those closest to them.

**If CPR will not restart the patient’s heart or maintain breathing**

If the clinical team is as clinically certain as it can be that attempting CPR would not re-establish effective circulation (and maintain breathing) then CPR need not be attempted. To provide CPR in such circumstances would justifiably not be in the patient’s interest. This is always an individual clinical decision that must be based on up-to-date knowledge of the patient’s condition. It is expected that in most situations that this will be discussed with the patient and with those closest to them.

**If the potential “harmful effects” of CPR is greater than potential benefits**

Any potential of benefit from CPR must be balanced against “risk of harm”. The patients recently expressed wishes are hence very important. If for example, a patient is in the final stages of an incurable illness and death is expected within a few days, CPR is unlikely to be successful and could prolong suffering. Best interest decisions in general are most easily reached in those circumstances where there is a clinical consensus that benefit is very low or risk of harm from CPR likely to be very high (See joint statement).

In some circumstances, a natural death free from the “invasive” intervention of CPR may be considered. It might be possible to reach a clinical position of a Natural Anticipated and Accepted Death (NAAD) with the patient (please see policy).
Deciding that a case warrants a DNACPR decision

The All-Wales DNACPR decision-making framework schematic is illustrated below. This includes clinical events that might act as a "trigger" for a team-based DNACPR discussion. It also outlines key questions clinicians that should ask themselves in order to decide if a DNACPR discussion is warranted.

**SCHEMATIC FRAMEWORK FOR DNACPR DECISION-MAKING**

**Question 1**
- **Is the clinical case a trigger for a CPR discussion? (A clearly possible cardiac arrest)?**
  - **Yes**
  - **No**

**Question 2**
- **Is attempting CPR likely to be clinically beneficial?**
  - **Yes**
  - **No**

**Question 3**
- **Does the patient have requisite mental capacity or is there an LPA for health & welfare for this decision?**
  - **Yes**
  - **No**

**Question 4**
- **Can an informed discussion take place?**
  - **Yes**
  - **No**

CPR

**Note for clinicians** - For details related to each box you MUST consult the accompanying complete All Wales DNACPR Policy

**No** - Refer to section 5.4 of All Wales DNACPR Policy relating to MCA
Further key issues relating to the Decision

When DNACPR status is unknown:

Unless a valid DNACPR decision is in operation with either an All Wales DNACPR form completed or a valid Specific Advance Decision to Refuse Treatment (ADRT) exists - all patients must be presumed to be “For CPR”.

When a valid Advance Decision Refusing CPR exists

If a valid Advance Decision to Refuse Treatment is in place (specifically relating to CPR) that was made when the patient had mental capacity and when the circumstance has arisen as envisaged (Mental Capacity Act 2005) then CPR should NOT be attempted.

Refusal of CPR by patients with capacity

Any person with capacity can personally refuse CPR. If a patient with capacity refuses CPR (even when it may be of benefit). This wish (and the discussions related to this) must be carefully and clearly recorded at the front of the patient’s record.
**Review of a DNACPR decision**

Should a “DNACPR review” be necessary in accordance with the policy a further DNACPR form needs to be completed only if the circumstances have clearly changed. A DNACPR review should always take place if requested by the patient.

A review of the DNACPR decision might, for example, be considered:

- When a patient’s overall clinical condition significantly and sustainably improves warranting further discussion.
- On the request of patient or individual(s) the patient has chosen to be present for the decision making process.

If a new discussion is warranted on clinical grounds the decision is subject to the same information sharing as the initial decision. If DNACPR is decided again then a new copy of the DNACPR form again must be handed to the patient or their advocate and communicated as per the All Wales policy.

**Cancellation of a DNACPR Decision**

In some circumstances it may be right to cancel a DNACPR decision. The original form should be clearly diagonally marked with 2 lines in black ink with “CANCELLED” written between the lines.

All parties who received copies the original decision (see reverse of All Wales DNACPR form) must be contacted and informed that the DNACPR has been cancelled.

The communication must be in writing and logged and contain a copy of the overwritten cancelled original document. The patient’s original copy should be returned and destroyed - in order to avoid future error.

**Clinical Note**

- A DNACPR decision relates specifically to wishes expressed in the event of a predictable cardiopulmonary arrest – applying only to CPR and it does not apply to any other aspects of treatment.

- In clinical practice unpredictable situations can occur in patients whilst a current DNACPR is in place (please see All Wales policy). In such instances the underlying cause requires maximal treatment and temporary CPR might become necessary whilst any reversible cause is correctly managed.

**For More Information**

Please refer to, “Sharing and Involving” a clinical policy for “Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) for Adults in Wales” and the Patient Information Leaflet – accompanying this document.