

DNACPR - FAQs

The DNACPR Form:

How long is the form valid for?/When should it be reviewed?/Should it be reviewed?

The decision should be reviewed whenever the patient's condition changes and prior to any proposed move between care settings. A timeframe for review should be stated on the form when it is first signed. Each patient needs to be assessed individually. E.g. six monthly review may be appropriate for a frail nursing home resident, whereas hourly may be more appropriate for a patient in A+E.

Is it valid when it hasn't been countersigned by the senior clinician?

The form is just the documentation of a decision regarding DNACPR. So for those who know this decision has been made appropriately an incomplete form does not invalidate the decision.

However, for those who do not know the patient an incomplete form may be sufficient justification to doubt the decision in the absence of any other information.

Who can make an advance DNACPR decision?/Who is a "Responsible Senior Clinician"?

The Responsible Senior Clinician is the person who takes responsibility for the advance DNACPR decision although it is always wise to gain consensus from the clinical team and the patient and relevant other where appropriate.

The responsible senior clinician is the most senior clinician assuming clinical responsibility for the patient during that care period who has the appropriate capability and knowledge. Although this person will usually be a GP or a hospital consultant it is also reasonable for this responsibility to be assumed by a Staff Grade Doctor, Associate Specialist, Nurse, Out of Hours Clinician etc.

Is the DNACPR form valid crossing care boundaries? Gen Hosp to home, hospital to hospice, Board to Board

Yes - as long as the senior clinician who takes over clinical responsibility for the patient in the new care setting is informed of, and is happy to take responsibility for, the DNACPR decision as appropriate to their clinical assessment. This responsibility also involves an undertaking to review the decision.

Do I need to discuss with Senior Clinician before filling in?

This should be decided between Senior Clinicians and their junior staff and may change according to the level of experience and capability of the junior staff. As with all aspects of clinical care, the senior clinician has responsibility for the decision and therefore has responsibility for the decisions made by their junior staff. Senior Clinicians need to be aware of the capabilities of their junior staff with regard to DNACPR decision-making as with all clinical decisions.

When should it be countersigned?

It should be countersigned as soon as practically possible and must be signed within 72hours.

Can it ever be photocopied?

Yes, for audit and medical record purposes but any photocopy should be scored through and "COPY" written across it to ensure it is not mistaken for the valid original form. A photocopy should never be used as a valid form in case the original has been changed or reversed in the meantime.

How many copies of the form can there be?

The fewer the better see above

If there is a DNACPR form is it ever right to initiate CPR?

There is always a clinical judgement to be made at the time of a cardiopulmonary arrest. Where the arrest is witnessed and it is clearly due to an easily reversible cause it may be appropriate to initiate CPR irrespective of the DNACPR order.

What if a patient with a DNAR form deteriorates unexpectedly?

Any patient who deteriorates unexpectedly should be assessed and managed appropriately whether there is a DNACPR form or not. This may involve calling 999 or putting out an arrest call in hospital to summon rapid medical assistance if that is appropriate. The decision not to attempt the procedure of cardio-pulmonary resuscitation detailed on the form does not preclude other interventions in situations other than a cardiopulmonary arrest but it may prompt different questions to be asked about what is happening to the patient.

Surely it's wrong for police to view the DNACPR form as a reason to not treat the death as suspicious?

The form itself simply allows the police to leave the patient's body in the house where all the professionals attending are as certain as they can be that there are no suspicious circumstances. These will not be situations where there is any doubt that police involvement is inappropriate. The police still require the GP to provide the death certificate the next working day before they can fully discharge the case.

Where there is no DNACPR Form:

If there is no DNA CPR form do you always have to initiate CPR when a patient has a cardiopulmonary arrest?

No, whilst there should always be a presumption in favour of CPR, where it is certain that CPR will not succeed it should not be attempted. This is a clinical judgment that can be made at the time of the cardiopulmonary arrest by healthcare staff who have sufficient capability to make this judgement and are certain in their knowledge of the patient's clinical condition.

What if a patient is found dead in bed (in hospital or at home/care home) who may or may not have been dead for some time?

It is not possible to construct a policy that can safely cover all the possibilities of unexpected cardiac arrest. If a patient is found unexpectedly in a state of cardiac arrest the resuscitation team or ambulance should be called unless there are obvious signs that resuscitation would be futile, such as icy coldness or rigor mortis.

Ultimately the decision about calling the resuscitation team must be made by the staff present at the time in the context of the circumstances, their knowledge of the patient, their own experience and DNAR orders in place.

The DNACPR Decision:

Why DNACPR rather than DNAR?

There has been confusion about what is meant by Do Not Attempt Resuscitation with some people interpreting this as Do Not Treat. DNACPR is used to emphasise that the decision / form relates **only** to cardio-pulmonary resuscitation in the event of a cardio-respiratory arrest. A DNACPR decision does **not** cover other interventions sometimes termed "resuscitation" e.g. parenteral fluids, antibiotics, ionotropes, treatment of choking / seizures / anaphylaxis etc. Separate decisions will need to be made about other treatment options and these decisions/ discussions recorded in the patient's record as appropriate. A patient who deteriorates unexpectedly should still be fully assessed.

When does a decision about resuscitation have to be made?

A decision needs to be made when it is clinically recognised that a cardiac or respiratory arrest can be anticipated. This may be because the patient is medically unstable, or because they are recognised to be imminently dying or because death would not be unexpected due to their underlying illness or general frailty.

If an arrest cannot be anticipated then no decision needs to be (or can be) made.

If a patient who lacks capacity has a valid advance directive which reflects the current clinical situation then a DNACPR should be completed as appropriate.

It will often also be appropriate to discuss CPR as part of advanced care planning in patients with life limiting illness and where death would not be unexpected This may include when patients are discharged from hospital or enter a care home.

What does "medically successful" mean?

A "Medically successful" treatment is one which achieves its aim and the aim of CPR is to achieve sustainable life in terms of breathing and circulation. This obviously includes maintaining a spontaneous cardiac output with a reasonable prospect of regaining spontaneous respiratory function. Some consideration must also be given to the prospect of irreversible anoxic cerebral damage - although these decisions cannot be made on the basis of healthcare professional's proxy view of patient quality of life.

How do I know for certain that CPR would be unsuccessful for a patient - surely there's always a chance?

Healthcare professionals tend to significantly overestimate the chances of CPR being successful.

Chances are increased if the arrest is witnessed and if staff with appropriate resuscitation equipment are immediately available. Success is also more likely if there is a reversible underlying cause e.g. pneumothorax/ hypoxia/ hypothermia/ tamponade etc.

Cardiopulmonary resuscitation in the event of a cardio-respiratory arrest secondary to a progressive, irreversible co-morbid disease e.g. cancer, hepatorenal failure, dementia etc has a negligible chance of success.

Who can make a DNACPR decision?

Ideally a DNACPR decision should be made electively as part of anticipatory care planning. The overall responsibility for making an advanced decision about CPR rests with the senior clinician who has clinical responsibility for the patient during that episode of care. This will usually be the medical consultant (acute hospital) or General Practitioner (in the community).

It is also reasonable that other senior medical staff and senior nursing staff (e.g. in nurse led community hospitals) take responsibility for the decision provided they have sufficient capability and accept that they have clinical responsibility for the patient during that care episode.

In some circumstances more junior members of medical staff may decide if CPR is appropriate, although this must be confirmed by the responsible senior clinician at the earliest opportunity.

Junior doctors without full GMC licence to practise should **not** make this decision.

Who makes the decision when the patient lacks capacity to be involved?

Staff must be aware of the AWI Act and the principles of assessing capacity.

If CPR will fail it is a clinical decision irrespective of the patient's capacity. If CPR might realistically be successful the decision rests with the healthcare team in conjunction with the legal welfare attorney /welfare guardian / person appointed under an intervention order. If there is no legally appointed welfare attorney /welfare guardian / person appointed under an intervention order the healthcare team must make a decision regarding the overall benefit for the patient. This decision will be made by finding out as much as possible about what the patient would have wanted through discussion with those who know the patient best. Any advance healthcare directive which is valid and applicable to the current clinical situation should also be respected.

What should happen to DNACPR decisions where the patient is undergoing surgery / General Anaesthetic?

By definition the patient's circumstances change when they are under anaesthetic/ peri-operative. The DNACPR status should therefore be reviewed. It may well be the case that a cardio-respiratory arrest is foreseeable peri-operatively, and crucially that resuscitation will have a significant chance of being medically successful - even in a patient who would in normal circumstances have a negligible chance of successful recovery following a cardio-pulmonary arrest.

Is there ever a place for an "opt in" system for DNACPR for some units?

It is considered unethical and probably illegal to make a blanket policy for a group of patients. In some circumstances such as NHS continuing care wards where patients are extremely frail and CPR would not be successful a senior nurse who knows the patient is not obliged to commence CPR. However it is good practice to discuss prognosis and goals for treatment with the patient, if appropriate, family and carers. This will often include discussion about resuscitation issues to help the patient and family understand the patient's condition.

The DNACPR Discussion:

Where can I get help about how to have a discussion about CPR?

You can access general advice about discussing CPR via the national DNACPR policy website at www.scotland.gov.uk/dnacpr

A copy of the training DVD may be obtained from your local resuscitation lead

There are various papers with guidelines available for example the BMJ website, DoH e-ELCA website

Should I always discuss with patient?

In certain cases it may be appropriate to document a DNACPR decision without making the patient aware that CPR is not a treatment that would work for them. There may be situations where the clinical team judge that the benefit for the patient in knowing that CPR would not work would be greatly outweighed by the likely burden of the distress such a conversation would cause for that patient. The conversation must never be avoided simply because it is too uncomfortable for the healthcare professional.

However the situation changes when the above patient (for whom CPR will not work) is being discharged home. In this circumstance the risk/benefits of a resuscitation discussion shift. The risk of that patient receiving an inappropriate attempt at CPR in the community must now be balanced against the potential distress of a resuscitation discussion. If the DNACPR form is to be sent home with the patient, it is of great importance that the patient's family/relevant others are made aware of the form and its positive role in ensuring that the patient has a natural and dignified death at home. Generally such discussions cannot take place without the patient's consent and therefore the patient needs to be made aware of the form also. Clearly there are some situations where consent to discuss the form with relatives is implicit within general consent from the patient to discuss all aspects of their end of life care.

Where CPR might work, and the decision would be based on a judgement of the overall benefit for the patient, the patient's views and wishes are of paramount importance. It is essential that the clinical team provide the patient with appropriate information in a sensitive manner to allow them to consent to or refuse the treatment of CPR.

Should I always discuss with the family/relevant others?

In order to keep families informed, if the patient is agreeable it is good practice to keep those closest to the patient informed of medical decisions unless it is judged that the burden of such a discussion would cause harm.

The family's role in CPR decisions is to assist in understanding the patients previously expressed wishes. It is important that families are not burdened with the feeling that they are making the decision about CPR themselves. The only time when family members can make CPR decisions is when they are legally appointed welfare attorney / welfare guardian/ person appointed by an intervention order for the patient.

Again, when a patient is being discharged home with their DNAR form it is important to discuss the purpose and meaning of the form with the patient and their relevant others. This is essential so that the form can be made available in order to prevent a full emergency response by ambulance crews and police in the event of a sudden cardiac arrest.

What about situations in hospital where the patient might see the form in their notes such as going for an x-ray etc?

It should be recognized that for patients where the likely distress of being informed or their DNACPR order is judged to be significant, the distress of coming across a DNACPR order out of context is likely to be even greater. This risk may be judged to be enough justification for such a conversation to take place.

Where the conversation has not taken place, care should be taken to protect the patient from unexpectedly discovering documents out of context which may cause distress. For example, in the event of a patient being transferred for a scan notes should be placed in a sealed package such as an envelope. Staff involved in the different areas of care should be made aware of the form and the patient's DNACPR status to minimize the potential risks of the patient inadvertently discovering or being given information inappropriately and without adequate support which may cause them severe distress.

What if the patient disagrees and refuses to accept that CPR would not work?

If the clinical team have made the decision that CPR has no realistic chance of success and would not be a valid treatment option they are not obliged to provide it, as with any other type of treatment. In this situation open and sensitive discussion by a senior member of medical or nursing staff is advised with the patient and relevant others. Patients often overestimate success rates of CPR and may hold misconceptions over what it involves, and sensitively explaining more about the process of CPR often highlights patient's misunderstandings. Reassuring patients about the treatments that they will receive may be helpful. It may also be helpful to say that if they deteriorate unexpectedly "everything possible will be done" to improve things for them as that is often the anxiety behind a refusal to accept a DNACPR form.

What if the patient wants a DNACPR form but the family disagree and want the decision reversed?

If the competent patient has made an informed decision regarding CPR, the patient's wishes are paramount and should be respected. The wishes of the family do not override those of the patient unless the patient lacks capacity and has a legally appointed welfare attorney / guardian, in which case they may influence the decision. Sensitive discussion and good communication with the patient and relevant others throughout the treatment process will often prevent these kinds of issues from arising, and resolve misunderstandings.

Where CPR won't work patients in hospital might be unaware of their DNACPR order on the ethical grounds that discussion may be too burdensome - why is that same discussion ethically justified for these patients when they are at home?

Where CPR won't work the decision to inform the patient that a DNACPR decision is appropriate is a judgement of the overall benefit to the patient in knowing that information. For a patient being discharged home there is significant benefit to them in knowing that CPR will not work as that allows them to have a DNACPR form at home. This benefit for the patient may well outweigh the potential burden of the distress of having that conversation. For patients in hospital the benefit for them of knowing that CPR will not work is less clear but opportunities for giving them that information in the context of advance care planning should be actively sought..

Discharge from Hospital/Hospice:

If a patient has a DNACPR order in their notes in hospital do I have to discuss it with them when they're being discharged?

The DNACPR decision should always be reviewed prior to discharge. The decision may have been made during an acute event from which the patient has made a full recovery such that a cardiorespiratory arrest can no longer be anticipated. If the possibility of a cardiac or respiratory arrest remains significant and CPR would clearly not be successful then it is important to consider the need to try and ensure a peaceful, natural and dignified death. Sensitive discussion should enable the patient and family to understand the benefit of having the form at home.

If it is judged that this discussion is not possible prior to the patient's discharge, as described in 4.2, the reasons for this must be clearly documented in the clinical notes and communicated to the GP. The original form can be sent to the GP who may wish to discuss it later when the patient is at home. Alternatively the form may be scored through and filed in the back of the patient's notes.

The original form should be shown to the ambulance crew so they are informed that the patient is not for CPR should they die in the ambulance.

What if CPR won't work but it's not been possible to discuss that with the patient on discharge home?

In most instances CPR should be discussed but on occasions where it would cause significant psychological distress then the GP must be informed that the team is of the opinion that CPR would fail and the reason why this has not been discussed with the patient. The GP can then transfer this information to the electronic Palliative Care Summary so it can be read by the ambulance service and the Out of Hours Service.

The form should not be left in the house if the patient and family are unaware of it.

Do I reverse the DNACPR decision if the form isn't going home with the patient because it hasn't been discussed?

The form should not be reversed unless the patient's condition has significantly improved. If the DNACPR remains appropriate the all relevant agencies should be informed of it. The form should be sent to the GP and a copy kept in the case notes. (It should be clearly marked that it is a copy.)

Consideration should be given to discussing the benefits of having the form with the patient.

For a patient being discharged home, if a discussion is felt to be appropriate, whose responsibility is it to discuss the DNACPR form with the patient before discharge home?

It is the responsibility to the most senior health care professional caring for the patient. This may be the consultant or senior nurse or may be delegated to a suitable colleague. The conversation must be documented in the notes and on the form.

If a decision is made that it is not appropriate to discuss the form with the patient this should also be documented clearly and this information should be passed to the GP who is assuming clinical responsibility for the patient at home.

What if it hasn't been discussed but I want to make sure the ambulance crew know the patient is not for CPR if the patient dies on the way home?

The ambulance crew need either the original form or they need to be shown the original form prior to the journey when the form is not to travel with the patient. They should also be told whether the patient and/ or family are aware that the form exists.

Does DNACPR have to be discussed with the patient/family before the patient is transferred to a care home?

It is good practice to discuss the decision with the patient and family when the form is completed. It will often form part of discussion and advance care planning on transfer to a care home. There are some patients who are so frail that it would not be appropriate to burden them or their families with this discussion.

DNACPR Forms at home:

Why should a patient have a DNACPR form at home?

Ideally a patient's family should be aware of what to do when the patient dies at home however occasionally a sudden collapse can prompt the family to panic and call 999 simply because they feel they need urgent help. In the absence of a DNACPR form, paramedics responding to an emergency callout must commence CPR if they find the patient has no pulse and respiratory effort. By having a completed DNACPR form, inappropriate CPR attempt and its consequences can be avoided. Out of hours GPs cannot provide a death certificate so police attendance at a death will result in removal of the patient's body to the police mortuary and investigation of the death as a suspicious death. The presence of a DNACPR form allows the police to leave the patient's body in the house if they are satisfied there are no suspicious circumstances.

Why does there have to be a form in the house if DNACPR is recorded in the ePCS and the GP notes?

The original DNACPR form must be accessible wherever the patient is being cared for. All relevant healthcare staff involved in the patients care must be aware of the DNACPR decision and form. The family must also be aware of the form so they are aware what to expect when the patient dies. It also places the paramedics in a very difficult situation if they arrive knowing CPR is not to attempted but are met by a family who are unaware of this and expecting everything to be done.

Where should the DNACPR form be kept at home?

The most important thing is that the family are aware of the form and where it is kept so they can show it to any healthcare staff who attend in an emergency. Where there are district nursing notes the form should be kept in the front of this folder. Some areas may have emergency systems in place such as the fridgebox or information tube where the form may be kept. In these areas a sticker will be applied near to the main access to the house to alert healthcare staff that medical information is available.

Who should know about the DNACPR form if it is at home with the patient?

The patient and their family, and all healthcare staff and social care staff involved in the care of the patient, must be aware of the DNACPR decision and form. This will include Scottish Ambulance Service staff, Out Of Hours staff, GP and District Nurses. When someone in their own home has a DNACPR form, the patient and relevant others must

be aware of the form and what to do if they are calling for an ambulance, for it to be of any use in an emergency situation. If possible, the ambulance crew should be alerted to the presence of a DNACPR decision and form at time of the emergency call. However, the crew will also look for the health information alert sticker and will check the emergency information tube to check for presence of DNACPR form.

DNACPR and AHP:

What do OTs and Physios do if they are taking a patient with a DNACPR form on a home visit?

The DNACPR form should accompany the patient. If the patient dies in the home they should contact the GP and ask him or her to attend to confirm death. If the patient deteriorates acutely and an ambulance is called the operator should be informed of the DNACPR.

What if a patient dies in the car on the way to or from a home visit?

The OT or Physiotherapist should contact the patients ward for advice but it is reasonable to call a paramedic ambulance to attend so death can be verified and the body moved appropriately. Ambulance control should be informed of the DNACPR order but advised that urgent assistance is required.

DNACPR and Social Carers:

Does a Social Carer have to respect a DNACPR form and not call 999 if a patient in their care suddenly collapses?

If the collapse is unexpected they should contact emergency services but inform them of the DNACPR form. If the patient is known to be in the very final days of their terminal illness they should contact GP or Out of Hours Service. Social Carers should never be expected to make a healthcare judgement.

What if a Social Carer doesn't agree with the idea of DNACPR?

They should discuss this with their manager and the clinical team caring for the patient.

What should a carer do if they are alone with a patient who collapses who has a DNACPR form?

If the collapse is sudden and unexpected they should contact emergency services but inform them of the DNACPR form. Social Carers are not expected to make medical or nursing decisions.

DNACPR and Care Homes:

Does every resident in a care home have to be asked if they want CPR?

As part of care planning patients in care homes should be asked about their wishes regarding their future care. This should usually include sensitive exploration of their feelings regarding CPR. It should be made clear that a DNACPR decision does NOT mean 'No Treatment' . There will be some patients who are so frail that CPR would

clearly fail and they and their families should not be burdened with CPR decisions but they should be given information about the patient's condition and prognosis and goals of treatment.

Does it have to be discussed with patients and their families before it can be recorded in the care home notes?

Good care planning should include discussion about the patient's condition, goals of treatment and prognosis and this will usually include discussion about CPR. Where possible the patient's own views should be sought. If this is not possible, for instance because of cognitive impairment, families and other carers should be consulted about the person's wishes and preferences. Unless the relative or carer has a Welfare Power of Attorney they do not have the right to make decision but should be consulted about the person's views. The ultimate decision about CPR rests with the most senior clinician caring for the patient.

What should happen if a resident in a care home collapses before a DNACPR decision has been made and recorded?

The senior nurse on duty should decide whether CPR is appropriate. In most cases the patient will be known to the staff. In the case of sudden collapse it may be appropriate to commence CPR, however, in most cases death follows progressive deterioration and a nurse would not be expected to commence CPR where the patient is clearly and irreversibly dying. If the patient has recently been admitted or is for respite and no DNACPR decision has been made they should initiate CPR.