**DNACPR Policy (England)**

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# Introduction

## Policy statement

At Sheerwater Health Centre, the default position is to attempt cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest unless there is an advance decision not to do so. Therefore, the aim of this DNACPR (Do not attempt cardiopulmonary resuscitation) policy is to:

* Ensure staff and patients are aware of the organisation’s requirements when a patient is not to be considered for CPR
* Improve the experience of patients and relatives
* Support the clinical professional in the delivery of patient care

The BMA, Resuscitation Council UK and RCN jointly state in their publication titled [Decisions relating to cardiopulmonary resuscitation](https://www.bma.org.uk/media/1816/bma-decisions-relating-to-cpr-2016.pdf):

*“The primary goal of health care is to benefit patients by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, leads to more harm or burden than benefit (from the patient’s perspective), ceases to benefit the patient or if an adult with capacity has refused treatment, that treatment is no longer justified.”*

This document is adopted from, and should be read in conjunction with, the Care Quality Commission (CQC)’s [GP Mythbuster No 105](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-105-do-not-attempt-cardiopulmonary-resuscitation-dnacpr) that was last updated on 21 April 2022.

This policy should also be read in conjunction with the following Health and Social Care Act 2008 (Regulation Activities) Regulations:

* [Regulation 9 (Person centred care)](https://www.cqc.org.uk/node/1752)
* [Regulation 10 (Dignity and respect)](https://www.cqc.org.uk/node/1753)
* [Regulation 11 (Need for consent)](https://www.cqc.org.uk/node/1754)
* [Regulation 12 (Safe care and treatment)](https://www.cqc.org.uk/node/1755)
* [Regulation 13 (Safeguarding service users from abuse and improper treatment)](https://www.cqc.org.uk/node/1756)
* [Regulation 17 (Good governance)](https://www.cqc.org.uk/node/1760)

## Background

During the COVID-19 pandemic between October 2020 and January 2021, the CQC acted upon concerns that decisions to not resuscitate were being made without involving people or their families and/or carers. It also found that a DNACPR decision was being applied to groups of people rather than considering each individual patient’s circumstances.

The CQC undertook a [review](https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19) into DNACPR and heard about the experiences and distress that people face when they do not feel involved in decisions about their care. It found that:

* When done well, DNACPR decisions are an important aspect of advance care planning
* Patients were often not fully involved in discussions about their care
* Every DNACPR decision must take account of each person’s individual circumstances or wishes. Often ‘blanket’ DNACPR decisions were in place

Within this review, the CQC found that there were three keys areas that required greater focus, these being:

1. Information, training and support
2. A consistent national approach to advance care planning
3. Improved oversight and assurance

## Terminology

The following abbreviations may be used:

* DNACPR – Do not attempt cardiopulmonary resuscitation
* DNAR – Do not attempt resuscitation
* DNR – Do not resuscitate

It should always be noted that patients need to be informed that DNACPR is about CPR only. It is not intended to be used to stop any other treatments.

## Principles

DNACPR decisions refer only to CPR and not to any other aspect of the individual’s care or treatment option. This policy can be applied to all individuals over the age of 16 years.

Whilst CPR can be attempted on any person prior to death, the chance of survival following CPR in adults is relatively low depending on the circumstances. Therefore, in some instances, there comes a time for some people for it not to be in their best interests to aggressively treat in this manner. It may then be appropriate to consider making a DNACPR decision to enable the person to die with dignity.

This policy will assist with a patient’s end-of-life advance care planning to identify those patients who would not want CPR to be attempted in the event of a cardiorespiratory arrest.

## KLOE

The CQC would expect any primary care organisation to have a policy to support this process and this should be used as evidence of compliance against CQC Key Lines of Enquiry (KLOE).

Therefore, at Sheerwater Health Centre, this policy is classified as *‘Expected’* and should be used as evidence of compliance against CQC KLOE[[1]](#footnote-1). Specifically, for patient participation, Sheerwater Health Centre will need to answer the CQC key questions on Safe, Effective, Caring and Responsive.

The following is the CQC definition of Safe:

*“By safe, we mean people are protected from abuse\* and avoidable harm.”*

*\*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.*

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| **CQC KLOE S1** | How do systems, processes and practices keep people safe and safeguarding from abuse? |
| **CQC KLOE S3** | Do staff have all the information they need to deliver safe care and treatment to people? |

The following is the CQC definition of Effective:

*“By effective, we mean that people’s care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence.”*

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| **CQC KLOE E1** | Are people’s needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes? |
| **CQC KLOE E3** | How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment? |
| **CQC KLOE E4** | How well do staff, teams and services work together within and across organisations to deliver effective care and treatment? |
| **CQC KLOE E6** | Is consent to care and treatment always sought in line with legislation and guidance? |

The following is the CQC definition of Caring:

*“By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.”*

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| **CQC KLOE C2** | How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible? |
| **CQC KLOE C3** | How are people's privacy and dignity respected and promoted? |

The following is the CQC definition of Responsive:

*“By responsive, we mean that services meet people’s needs.”*

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| **CQC KLOE R1** | How do people receive personalised care that is responsive to their needs?  |
| **CQC KLOE R2** | Do services take account of the particular needs and choices of different people? |

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have with regard to the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

## Training and support

The organisation will provide guidance and support to help those to whom it applies to understand their rights and responsibilities under this policy. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.

Relevant courses are available on e-learning platform, Blue Stream Academy

# Scope

## Who it applies to

This document applies to all employees, partners and directors of the organisation. Other individuals performing functions in relation to the organisation, such as agency workers, locums and contractors, are encouraged to use it.

Furthermore, it applies to clinicians who may or may not be employed by the organisation but who are working under the Additional Roles Reimbursement Scheme (ARRS).[[2]](#footnote-2)

## Why and how it applies to them

All Sheerwater Health Centre staff are to be aware of the requirement to consider a DNACPR decision that respects, where possible, the wishes of the individual whilst reflecting their best interest.

Any DNACPR decision will consider the benefits of attempting CPR and if this outweighs any potential burdensome or negative outcome.

# Legislation and professional guidance

## Mental Capacity Act 2005

In England and Wales, advance decisions are covered by the Mental Capacity Act 2005 whilst In Scotland and Northern Ireland an Advanced Decision to Refuse Treatment (ADRT) is not covered by statute but it is likely that it is binding under common law.

In accordance with the [Mental Capacity Act 2005](https://www.legislation.gov.uk/ukpga/2005/9/contents), clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

For further reading and insight, refer to the [Mental Capacity Act Policy](https://practiceindex.co.uk/gp/forum/resources/mental-capacity-act-policy.1105/).

## Human Rights Act 1998

Policies and individual decisions about CPR must comply with the Human Rights Act 1998. To meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention.

The following areas of the [Human Rights Act 1998](https://www.legislation.gov.uk/ukpga/1998/42/contents) are relevant to this policy:

* The individual’s right to life
* To be free from inhuman or degrading treatment
* Respect for privacy and family life
* Freedom of expression, which includes the right to hold opinions and receive information
* To be free from discriminatory practices in respect to those rights

## Mental Capacity (Amendment) Act 2019

In addition to the Mental Capacity Act 2005, an amendment to the Act was made in 2019 to support procedures where a person may be deprived of liberty where the person lacks capacity to consent.

This is covered in the [Mental Capacity (Amendment) Act 2019](https://www.legislation.gov.uk/ukpga/2019/18/enacted/data.htm).

## Independent mental capacity advocacy

An independent advocate may be required in the form of an Independent Mental Capacity Advocate (IMCA). The primary focus of IMCAs in safeguarding adults’ proceedings relates to the decisions concerning protective measures (including decisions not to take protective measures).

IMCAs have a statutory role to represent and support the person at risk in relation to these decisions which must comply with the MCA.[[3]](#footnote-3)

## Lacks capacity

‘Lacks capacity’ is a term used to describe a person who lacks capacity in relation to a matter if, at the material time, they are unable to decide for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.[[4]](#footnote-4)

## Approved Mental Capacity Professionals (AMCPs)

Approved Mental Capacity Professionals (AMCPs) are practitioners with specialist training in the MCA whose role is to provide an independent check, known as a pre-authorisation review, on whether the conditions for a deprivation of liberty have been met.[[5]](#footnote-5)

## Lasting Power of Attorney (POA)

A lasting power of attorney (LPA)[[6]](#footnote-6) is a legal document that lets a patient (the ‘donor’) appoint one or more people (known as an ‘attorney’) to help decide or to make decisions on their behalf.

This gives the person more control over what happens should they have an accident or an illness and can no longer make their own decision as they then lack mental capacity.

A person must be 18 years or over and have mental capacity when they make an LPA.

# Supporting DNACPR

## Requirements

Clinicians, professionals and workers must have the knowledge, skills and confidence to speak with the patient about, and support them in, making decisions about resuscitation.

Effective communication is essential. Decisions about CPR must be well made. They must be clearly understood by everyone involved. There should be communication with the patient and those close to them (unless they have requested confidentiality).

This should be:

* Accurate
* Clear
* Honest
* Timely

It should include:

* Provision of information
* Checking their understanding of what has been explained to them

[Resuscitation Council UK guidance on DNACPR and CPR decisions](https://www.resus.org.uk/library/additional-guidance/guidance-dnacpr-and-cpr-decisions) includes information for patients and their families.

## Person centred care

Patients must always be at the centre of their care including advance care planning and DNACPR decisions. Everyone needs to have access to personalised support around DNACPR decisions. This should be equal, non-discriminatory and support their human rights.

Patients, families and representatives need to be supported as partners in personalised care. They should understand what good practice looks like for DNACPR decisions. They should all share the same understanding and expectations for DNACPR decisions.

It is important that care workers and the patient understand the patient’s legal rights.

## Decision making

A DNACPR decision is usually part of the advance care plan discussion.

As part of any decision-making process, the patient should be made aware that DNACPR is about CPR only. Clinicians at Sheerwater Health Centre will always advise patients that they will still receive other appropriate care and treatment. This is in line with any advance directives or treatment escalation plans in place.

For many patients, anticipatory decisions about cardiopulmonary resuscitation are best made in the wider context of advance care planning. This is before a crisis requires a hurried decision in an emergency setting. The General Medical Council (GMC) has published [guidance for providers on decision-making models](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/decision-making-models) which explains what options are available for patients with and without capacity.

Every decision must be made based on a careful assessment of each patient’s situation. Decisions must never be dictated by ‘blanket’ policies. Decisions must be based on clinical judgement and free from any discrimination, for example, disability or age. The decision must also not be based on a subjective view of a person’s quality of life. Accessible information should be used. This may include easy read, translation or interpretation services if needed.

Not everyone will want to make decisions regarding advance planning and future care although support may be especially relevant for:

* Patients at risk of losing mental capacity, say through progressive illness
* Patients whose mental capacity may fluctuate, for example those living with a mental health condition

Additionally, clinicians will need to consider some or all the following when planning to discuss DNARCPR with a patient:

* An assessment of the individual’s situation
* Do they have capacity?
* Is there an appointed legal representative or is a Lasting Power of Attorney in place?
* Is there a clinical need to make a decision?
* Is it in the best interest of the patient?
* Is the patient willing to discuss it at this time?

## Advance care planning

An advance care plan involves considering and discussing how patients want to be supported and what matters most to them should they become seriously unwell or if they are approaching the end of their life.

The advance care plan involves talking and exploring options with family members, loved ones, carers and healthcare professionals about matters that are wanted, such as:

* Type of care
* Admission to hospital or to remain at home
* Refusal of any types of treatment

Discussions such as these may not be easy topics to consider or discuss but patients who plan and discuss their wishes in advance can ensure that they receive the care and support that is specifically requested.

In addition to supporting patients, any care planning can guide Sheerwater Health Centre staff in their decision making about emergency care and treatment if at any stage consent should be unobtainable due to capacity.

The Royal College of Nursing (RCN) has published appropriate guidance and resources on [Advance Care Planning](https://www.rcn.org.uk/clinical-topics/End-of-life-care/Advance-care-planning).

## ReSPECT

ReSPECT, or Recommended Summary Plan for Emergency Care and Treatment, is a process used to encourage a conversation to create a recorded summary of personalised recommendations for a person’s clinical care in a future emergency if they do not have capacity to make or express choices.

It should be noted that neither ReSPECT nor DNACPR forms are legally binding, and GPs will need to use clinical judgment so may decide not to follow the recommendations on a ReSPECT form.

The forms are a guide to immediate decision-making. Recommendations are made through conversations between the patient, their families and health and care professionals. They are recorded on the appropriate form. Patient preferences and clinical recommendations are recorded on the non-legally binding form. The form can be reviewed and adapted if circumstances change.

Resuscitation Council UK has published [ReSPECT guidance for healthcare professionals](https://www.resus.org.uk/respect/respect-healthcare-professionals).

## Actions required when deciding upon DNACPR

Decisions should be frequently reviewed based on the person’s individual circumstances. Reviews allow a change in decision (in either direction) following the person’s clinical progress, or lack of.

The joint guidance from [British Medical Association (BMA), Resuscitation Council UK and Royal College of Nursing (RCN)](https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation) dated 13 August 2021 details the legal and ethical factors that need to be considered about DNACPR.

The following actions are needed when considering CPR:

* Decisions about CPR should be reviewed at appropriately frequent intervals
* A future date of review should be planned and recorded, specifically, whenever changes occur in a person’s condition or in their expressed wishes.

This applies to a decision where CPR is appropriate as well as to a DNACPR decision.

* The frequency of review should be determined by the healthcare professional responsible for their care and this is to be influenced by the clinical circumstances of the patient.
* Any changes in CPR status are discussed and communicated properly

## Advance Decision to Refuse Treatment (ADRT)

Patients may opt to complete an advance decision form. An advance decision is a decision patients can make to refuse a specific type of treatment at some time in the future. The scope of treatments the patient is deciding to refuse will be in the advance decision. Advance decisions are sometimes known as an advance decision to refuse treatment, an ADRT or living will.

NHS England has published [guidance on the end of life care and advanced decision to refuse treatment](https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/) (advance decision living will). It states that an advance decision is legally binding if it:

* Complies with the Mental Capacity Act
* Is valid
* Applies to the situation

As the advance decision is binding, it take precedence over decisions made in the patient’s best interest by other people.

Further reading on ADRT can be found at [Section 6.1](#_ADRT).

# Children and young persons under 18 years of age

## Requirements

Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, parents and the healthcare team.

As with adults, decisions about CPR must be made based on an individual assessment of each child or young person’s current situation. It is not necessary to initiate a discussion about CPR if there is no reason to believe that the child is likely to suffer a cardiorespiratory arrest.

If CPR will not restart the heart and breathing, it should not be attempted. Often these decisions are made in the context of a wider decision-making framework, for example, in Scotland as part of the [Children and Young Persons Acute](https://www.cen.scot.nhs.uk/wp-content/uploads/2017/01/ResucPlanningPolicyCYPADM.pdf)

[Deterioration Management (CYPADM) framework](https://www.cen.scot.nhs.uk/wp-content/uploads/2017/01/ResucPlanningPolicyCYPADM.pdf).

As with adults, difficulties can arise where CPR may restart the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the potential harms and burdens. In these cases, the views of the child or young person should be taken into consideration, where possible, in deciding whether CPR should be attempted.

## Legal considerations

Usually, it is possible to reach agreement on whether CPR should be attempted. If it is not possible to reach agreement between the patient, the individuals with parental responsibility and the healthcare team, legal advice should be sought.

Clinicians cannot be required to provide treatment contrary to their professional judgement although they should try to accommodate the child’s and parents’ wishes where there is genuine uncertainty about the young person’s best interests.

If legal advice is required, this should be sought in a timely manner.

# Documentation and record keeping

## ADRT

At Sheerwater Health Centre, should a patient wish to make a refusal of CPR legally binding for when in the future they may not be able to make this decision, then the patient should write an [Advance Decision to Refuse Treatment (ADRT).](https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/)

An ADRT explains to the clinical team whether the patient wants to refuse CPR (or other treatments).

Whilst the patient has the final say, they must be advised that family, carers or those who provide their health and social care should be informed about any ADRT decision and documentation about the decision and where this can be found as this may be needed quickly should emergency treatment be needed and will enable the healthcare professionals to understand the patient’s wishes.

## ReSPECT form

\*An electronic ReSPECT form may be established to sit within the patient record system.

Should this be required, contact info@respectprocess.org.uk although note that any form developed will need to be submitted for approval before being adopted for use.

## Record keeping and communication

At Sheerwater Health Centre, we will detail full records of conversations with, and decisions agreed with, the patient, their families and representatives that support them to move around the system well.

These records will be accessible to those involved in the patient’s care and will detail discussions about patient’s needs, wishes and preferences that have been completed. The Medical Defence Union (MDU) [advice and guidance document](https://www.themdu.com/guidance-and-advice/guides/dnacpr-orders) suggests providers should:

* Make a clear note in the patient's records about the DNACPR discussion and the reasons for recommending a DNACPR order
* Ensure DNACPR decisions are communicated to everyone involved in the patient's care, for example, care home staff and the nursing team

Copies of any forms will be kept electronically on EMIS Web system, clearly highlighted in the patient record for easy access and a copy should be printed and left with the patient at their residence/care home[[7]](#footnote-7).

Furthermore, there will be a requirement to ensure the information is made available to the OOH services including NHS111 and the NHS Ambulance Trust. This may be detailed as an update using recognised local process.

## Review

Reviews about DNACPR decisions should be undertaken at appropriate intervals and may include changes to a person’s medical condition or in their expressed wishes. The frequency of any review should be led by the healthcare professional responsible for their care. A patient’s ability to participate in decision-making may alter with changes in their clinical condition.

EMIS web medical record should be updated, coupled with any other documentation held by the patient or other third-party organisation as detailed at [Section 6.3](#_Disposal_of_the).

## DNACPR across other services

Patients need to have a seamless experience of care and this can often be an issue when moving around the health and care system. As such, any recorded decisions about CPR should accompany a patient and be accessible to those contributing to the patient’s care, especially should they move from one setting to another.

[GMC guidance](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/cardiopulmonary-resuscitation-cpr) suggests providers make sure that all those consulted, especially those responsible for delivering care, are informed of the decisions. They are clear about the goals and the agreed care plan.

It should be noted that the patient may indicate that certain individuals should not be informed.

GPs and practice staff should use available systems and arrangements so the agreed care plan is shared with:

* The healthcare team
* Carers
* Other health professionals involved in providing the patient’s care.

This is particularly important when patients move across different care settings (hospital, ambulance, care home) and during any out-of-hours period as failure to communicate some or all relevant information can lead to inappropriate treatment.

# Training and governance

## Staff training

DNACPR decisions and conversations should be undertaken by members of the healthcare team who are:

* Appropriately trained
* Competent
* Experienced

At Sheerwater Health Centre, training will enable our professionals to have the knowledge, skills and confidence to talk to the patient and their relatives or carers about advance care planning and DNACPR decisions.

Discussions may include the level of care and treatment patients wish to receive as they reach the end of their lives.

Training will:

* Help professionals to ensure they are holding these conversations at the appropriate time
* Advise them to always take a personalised approach and put the patient at the centre of their care
* Promote the need to ensure that the patient’s human rights and rights to equal treatment are always considered and protected

[BMA/RCN guidance](https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation) states that organisations providing healthcare must make sure their clinical staff have up-to date knowledge and adequate training to:

* Make appropriate decisions about CPR
* Give relevant information to patients and those close to them
* Communicate effectively with patients and those close to them
* Support the involvement of patients and those close to them through sensitive discussions
* Undertake appropriate reviews of decisions about CPR

## Governance

At Sheerwater Health Centre, Dr M Mohamed is the DNACPR coordinator.

The DNACPR coordinator will ensure that all have an oversight of any decisions made with advance care planning, end of life care and DNACPR and that they are discussed during the staff meetings.

The DNACPR coordinator will also:

* Monitor and assure the quality of DNACPR decisions
* Audit and learn from any incidents relating to DNACPR decision making processes to enable any improvement to patients’ experiences
* Ensure any complaints and concerns about DNACPR decisions are discussed
* Liaise with any external organisation as appropriate should the patients care be shared
* Promote the understanding of DNACPR within the organisation
* Promote how to speak up to ensure that all are confident to speak up and be supported and listened to when they do speak up

# CQC regulatory assessment during inspection

Organisations are reminded that as part of a CQC regulatory assessment, the inspection team may seek assurance that patients are at the centre of personalised, high quality and safe experiences of DNACPR decisions that protect their human rights.

The review will look for evidence to show that:

* Decision-making processes are in line with the Mental Capacity Act 2005, they are based on clinical judgement and are free from any discrimination.
* Decisions have been communicated in an accessible way and that they meet the patient’s needs and are documented appropriately.
* Organisation staff take the patient’s preferences into account, ensuring they have the time, support and training to be able to have sensitive and ongoing conversations.
* The patient’s legal rights are understood by the patient, their family and care workers
* Effective leadership, governance and assurance processes are in place.

# Further reading

* BMA [Ethics](https://www.bma.org.uk/ethics) guidance
* [Decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108) (NICE guideline including implementation resource)
* Joint BMA, RCUK and RCN document titled [Decisions relating to cardiopulmonary resuscitation](https://www.bma.org.uk/media/1816/bma-decisions-relating-to-cpr-2016.pdf)
* [Mental Capacity Act Code of Practice](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice) (available from Office of the Public Guardian)
* [My future wishes: Advance care planning for people with dementia in all care settings](https://www.england.nhs.uk/publication/my-future-wishes-advance-care-planning-acp-for-people-with-dementia-in-all-care-settings/) (NHS England)
* [Planning for your future care: a guide](https://www.nhs.uk/planners/end-of-life-care/documents/planning-for-your-future-care.pdf)  (An information source for people considering advance care planning - NCPC/University of Nottingham/National End of Life Care Programme)
* [Resuscitation Council UK](http://www.resus.org.uk/) (RCUK) provides guidance for clinicians and patients regarding both CPR and DNACPR

# Summary

Survival following CPR in adults is between 5% and 20% depending on the circumstances and, due to the nature of the treatment, in some circumstances CPR can do more harm than good causing injuries such as punctured lungs or fractured ribs.

Whilst DNACPR can be a complex and difficult area to discuss with patients, having the supporting documentation and information at hand may help those involved in their consideration of any decision.

1. [KLOE](https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20showing%20changes%20FINAL.pdf) [↑](#footnote-ref-1)
2. [Network DES Contract specification 2022/23](https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-Network-Contract-Directed-Enhanced-Service-contract-specification-2022-23-primary-care-network-requireme.pdf) [↑](#footnote-ref-2)
3. [Social Care Institute for Excellence – The role of the IMCA](https://www.scie.org.uk/publications/guides/guide32/imcarole.asp) [↑](#footnote-ref-3)
4. [MCA 2005 – People who lack capacity](https://www.legislation.gov.uk/ukpga/2005/9/part/1) [↑](#footnote-ref-4)
5. [Community Care Function of new AMCP role](https://www.communitycare.co.uk/2018/11/29/government-extend-remit-approved-mental-capacity-professionals-dols-replacement-scheme-improve-protections-service-users/) [↑](#footnote-ref-5)
6. [www.gov.uk](https://www.gov.uk/power-of-attorney) [↑](#footnote-ref-6)
7. [NHS - Advance decision (living will)](https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/) [↑](#footnote-ref-7)