Policy No: RM27b  
Version: 5.0

Name of Policy: Do Not Resuscitate Policy

Effective From: 1st October 2009

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This policy supersedes all previous issues.
## Version control

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Appendices

Appendix 1: Do not resuscitate order form
1. Introduction

Patients' rights are central to decision making on resuscitation. All patients within the Trust will normally receive cardio-pulmonary resuscitation (CPR) if the need unexpectedly arises. If a Do Not Resuscitate (DNR) Order has been issued then the cardiac arrest team/paramedic ambulance need not be summoned and CPR need not be initiated.

This policy is only applicable to the cardiac or respiratory resuscitation status of individual patients and must not be confused with decisions to continue other appropriate medical treatment.

2. Policy scope

The policy applies to all clinical members of staff working within the Gateshead Health NHS Foundation Trust who are involved in any aspect of service delivery.

3. Aim

The aim of this policy is to guide clinical staff in the planning and delivery of care to any patient who may require CPR attempts, in circumstances where, for whatever reason, it may be inappropriate to commence such intervention. CPR is an attempt to restore breathing and spontaneous circulation in a patient who has suffered a cardiac and/or respiratory arrest. CPR is an invasive procedure that usually includes chest compressions, attempted defibrillation, and administration of drugs and ventilation of the lungs.

4. Duties – Roles and responsibilities

4.1 Trust responsibilities

The main objective of this document is to ensure that patient’s who are not to be resuscitated are clearly identified, and that the decision not to resuscitate is clearly documented and communicated to all staff involved in that patient's care. Gateshead Health NHS Foundation Trust shall ensure that a non-executive Director of the Trust is given designated responsibility on behalf of the Trust Board to ensure that this resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework.

4.2 Healthcare professional responsibilities

The final responsibility as to whether a patient is to be resuscitated or not most commonly rests with that patient's Consultant. In reaching this decision all relevant factors should be taken into consideration including clinical outcome, quality of life, the patient’s expressed or reflected wishes and the views of the multidisciplinary team. The decision not to resuscitate should be
documented in the notes together with the rationale for such a decision and any relevant discussions that have taken place.

**A DNR form should be completed in full and attached inside the front cover of the patient’s medical notes.**

Sections 1 to 5 of the form should be completed in full and section 6 of the DNR form should be signed and dated by the healthcare professional completing the form. Section 7 of the DNR form should be endorsed by the consultant leading the patient’s care at the earliest opportunity. It is the responsibility of the senior healthcare professional completing the form to ensure that all staff who may be involved with the patient’s care are aware of the DNR order. Clinicians making the decision to refuse CPR should document the reasons for refusal clearly in the patient’s notes. Any clinician may be asked to justify their decision.

Directions on completion of the form can be found on the rear of the DNR form and in Appendix 1 of this policy.

**4.3 Employee responsibilities**

Employees have a duty to ensure they are aware of the resuscitation status of all patients they come into clinical contact with. This policy applies to all staff who may be involved in a resuscitation attempt.

**5. Definitions**

Throughout this policy the terms basic life support, BLS, and CPR are to be recognised as cardiopulmonary resuscitation. DNR and DNAR (as used by the Resuscitation Council UK) are to be recognised as a formal order not to commence cardiopulmonary resuscitation in the event that a person stops breathing and/or the heart stops beating.

**6. Recommended considerations in relation to CPR and DNR Orders**

**6.1 Presumption in favour of CPR**

If no explicit decision has been made in advance about CPR, and the wishes of the patient have not been obtained, then health professionals will presume all reasonable efforts to attempt to revive the patient in the event of cardiac or respiratory arrest should be made. Medical and nursing colleagues should support anyone attempting CPR in such circumstances. There may be some situations in which CPR is commenced on this basis, but during the attempted resuscitation further information arises that highlights the resuscitation attempt as inappropriate. In such circumstances, continued attempted resuscitation should be ceased, and the reasons clearly documented.

There will be some patients for whom attempting CPR is clearly inappropriate; for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR decision has been made. **In such circumstances, healthcare workers who make a considered decision not to commence CPR should be supported by their senior colleagues and employers.**
6.2 Discussing DNR decisions with patients

In the majority of terminally ill patients there is no ethical obligation to discuss CPR and the raising of such issues may indeed be redundant and potentially distressing. The definition of terminal illness specifically includes patients with advanced cardiac, respiratory and cerebrovascular disease, not just those with malignant disease (cancer).

It is not always appropriate to discuss every DNR decision with every patient, and consideration should be given to the benefits and advantages of doing so. It is anticipated that in most cases the patient would be informed of this decision, but in such cases where the patient is knowingly approaching the end of their life there may be little benefit in discussing any clinical intervention that would be inappropriate or unsuccessful. Where a patient has indicated that they wish to be informed and involved in every aspect of their care their wishes should be respected. The decision must be the right one for each patient, and not avoided because of any discomfort on behalf of the health care team. The clinician must consider that patients have a legal right to see their health care records, and it may be distressing to find a DNR decision has been made that they have not been consulted about, or have not been informed of. When a patient with capacity is at foreseeable risk of cardiac or respiratory arrest, and the healthcare team has doubts about whether the benefits of CPR would outweigh the burdens, or whether the level of recovery expected would be acceptable to the patient, then the patient’s wishes should be indentified and taken into account in the treatment provided to that patient.

It should be noted that information should not be forced on unwilling recipients and if patients indicate that they do not wish to discuss CPR this should be respected. Any discussions with the patient about whether to attempt CPR and any anticipatory decisions should be documented, signed and dated in the patient’s health record. If a DNAR decision is made and there has been no discussion with the patient because they have indicated they do not wish to discuss it, then this should be documented also. A decision making framework that may prove a useful guide for the practitioner considering a DNR decision can be found on the rear of the DNR form and in appendix 1 of this policy.

6.2.1 Clarifying what “DNR” means.

Clinical practitioners should ensure that any communication with patients, carers, attorneys or advocates is clear that a DNR order is specific to not commencing CPR, defibrillation and the overall attempt at cardiopulmonary resuscitation.

It should be clarified that all other treatments and interventions will not be withheld under the premise of a DNR order.

6.2.2 Discussion if the patient lacks capacity.

The following sub-sections (6.2.2 to 6.2.5) explain who should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales). Decision-making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast to far-reaching decisions about serious medical treatment, such as CPR. In a
legal context it refers to a person’s ability to do something, including making a decision, which may have legal consequences for the person or for other people. Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless there is evidence to the contrary. Individuals are, however, considered legally unable to make decisions for themselves if they are unable to:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decisions, or
- communicate the decisions (whether by talking, using sign language, visual aids or by other means).

If the patient lacks capacity then the clinical decision should be made in consideration of the views of any individual to whom the patient has granted a lasting power of attorney or to any court appointed deputy. The authority of either of these individuals extends to informing clinical decisions on behalf of the patient. They should be informed of any clinical decision taken in respect of the patient and the reasons for them. **Guidance on the process for appointing an Independent Mental Capacity Advocate (IMCA), and the forms required to do so, are available from the Trust intranet on the Equality, Diversity and Human Rights page under “Resources & Information”**.

If a patient lacks capacity, any previously expressed wishes should be considered when making a CPR decision. Whether the benefits of CPR would outweigh the risks and burdens for the particular patient should be the subject of discussion and agreement between the healthcare team and those close to or representing the patient. Only relevant information should be shared with those close to the patient unless, when they were previously competent to do so, the patient has expressed a wish that information be withheld. Consulting with those close to the patient in these cases is not only good practice but is also likely to be a requirement of the Human Rights Act (Articles 8 – right to private and family life and 10 – right to impart and receive information), the Mental Capacity Act 2005 (England and Wales).

**Clinicians should ensure that those close to the patient, who have no legal authority, understand that their role is to help inform the decision-making process, rather than being the final decision-makers.**

Great care must be taken when people other than the patient make or guide decisions that involve an element of quality-of-life assessment, because there is a risk that health professionals or those close to the patient may see things from their own perspective and allow their own views to influence their decision. The important factor is whether the patient would find the level of expected recovery acceptable, taking into account the invasiveness of CPR and its low likelihood of success. Communication about CPR and DNAR decisions is complex and sensitive. It should be undertaken by experienced members of the healthcare team who have the necessary skills and knowledge to undertake discussions with patients and with those close to or acting for patients.
6.2.3 Patients with a welfare attorney or court-appointed deputy or guardian

If patients lack capacity and have a welfare attorney or guardian, this person must be consulted about CPR decisions. In England and Wales the Mental Capacity Act allows people over 18 years of age who have capacity to make a lasting power of attorney (LPA), appointing a welfare attorney to make health and personal welfare decisions on their behalf once such capacity is lost. Before relying on the authority of this person, the healthcare team must be satisfied that:

- the patient lacks capacity to make the decision
- a statement has been included in the LPA specifically authorising the welfare attorney to make decisions relating to life-prolonging treatment
- the LPA has been registered with the Office of the Public Guardian
- the decision being made by the attorney is in the patient’s best interests.

In England and Wales neither welfare attorneys nor deputies can demand treatment that is clinically inappropriate. However, if CPR may be able to re-start the heart and breathing for a sustained period and a decision on whether or not to attempt CPR is based on the balance of benefits and burdens, their views about patients’ likely wishes must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney or court-appointed guardian about whether CPR should be attempted in the event of cardiorespiratory arrest and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration. More information about welfare attorneys, deputies and the Mental Capacity Act can be found in the Mental Capacity Act Code of Practice.

Any second opinion should be sought in a timely manner.

6.2.4 Adults who lack capacity who have neither an attorney nor an advance decision but do have family or friends

Where a patient has not appointed a welfare attorney or made an advance decision, the treatment decision rests with the most senior clinician in charge of the patient’s care. Where CPR may re-start the patient’s heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient’s best interests. In order to assess best interests, the views of those close to the patient should be sought, unless this is impossible, to determine any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR. In England and Wales the Mental Capacity Act requires that best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, anyone engaged in caring for the patient or interested in the patient’s welfare. Under the Act, all healthcare personnel, for example doctors, nurses and ambulance crew, must act in the best interests of a patient who lacks capacity.

6.2.5 Adults who lack capacity and have no family, friends or other advocate whom it is appropriate to consult
In England and Wales, the Mental Capacity Act 2005 requires an independent mental capacity advocate (IMCA) to be consulted about all decisions involving serious medical treatment where patients lack capacity and have nobody to speak on their behalf and the decision is made by an NHS body or Local Authority. The definition of serious medical treatment includes circumstances where what is proposed would be likely to involve serious consequences for the patient. It can be argued that a decision not to attempt CPR because it appears certain that it will not work will not have ‘serious consequences’ for the patient, because the patient will die with or without attempting CPR. For this reason:

An IMCA does not need to be called when it is clear to the medical team that CPR would not re-start the patient’s heart and breathing for a sustained period. Nevertheless, neither the Act, nor the code of practice, differentiates between decisions made purely on clinical grounds and those that involve broader best-interests considerations and so it needs to be acknowledged that there is still some uncertainty in this area. Where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a DNAR decision is being considered on the balance of benefits and burdens, in order to comply with the law an IMCA must be involved in every case.

If a DNAR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made by the medical team in the absence of the IMCA and recorded in the health record. The decision should be discussed with an IMCA at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician in charge of the patient’s care as part of the determination of the patient’s best interests.

6.2.6 Children and young people
Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and the healthcare team. Where CPR may re-start the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the burdens, the views of the child or young person should be taken into consideration in deciding whether it should be attempted. Young people with capacity are entitled to give consent to medical treatment, and where they lack this capacity, it is generally those with parental responsibility who make decisions on their behalf.

In England, refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment. Where a young person with capacity refuses treatment, the potential harm caused by violating the young person’s choice must be balanced against the harm caused by failing to give treatment.

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

Paediatric DNR forms may be found in the paediatric ward on the Queen Elizabeth Hospital site (Appendix 2 – Paediatric DNR form).
6.3 Decisions not to attempt CPR

In some cases the decision not to attempt CPR is a straightforward clinical decision. If the clinical team believe that commencing CPR will not start the heart or the breathing then it should not be offered or attempted. The responsibility for making such decisions lies ultimately with the most senior clinician delivering the patient’s care, but wherever possible the decision should be agreed with the entire health care team. The most senior clinician in the clinical areas is usually the consultant leading on that patient’s care, but in some cases could be a GP who has been or is involved in the patient’s care.

6.3.1 Unexpected reversible causes.

In extreme cases a patient who has a current DNR order may develop a cardiac or respiratory arrest due to an unexpected reversible cause, such as choking, anaphylaxis or a blocked tracheostomy tube. In these cases it would be appropriate to treat these reversible causes and attempt resuscitation, unless the patient has expressly refused any intervention.

6.3.2 Temporarily suspending DNR orders.

In addition to unexpected reversible causes, it may be appropriate to temporarily “suspend” a DNR order during certain procedures. Examples such as cardiac pacemaker insertion, general anaesthesia, and cardiac catheterisation may be valid procedures in which a DNR Order may be temporarily suspended. Ideally the DNR decision should be discussed prior to the procedure with the patient or their representative if the patient lacks capacity. **This should be considered as part of the consent process.** If the patient wishes the DNR to remain valid during any procedure that increases the risk of cardiorespiratory arrest (such as cardiac surgery), this may significantly increase the risk of the procedure. If the clinician believes that upholding the DNR decision during the procedure would render the procedure to be unsuccessful, then it would be reasonable not to proceed with the procedure.

6.3.3 Requests for resuscitation against the views of clinicians.

No patients, carers, attorney or advocate can demand any treatment that is clinically inappropriate. If the health care team believe that CPR will not re-start the heart and breathing, then it should not be attempted. This should be discussed with the support of a senior clinician, and if necessary, a second opinion may be sought. Clinicians cannot be expected to deliver treatment contrary to their clinical judgement, but they should be willing to consider and discuss the patient’s views of proposed treatments.

6.4 Refusal of CPR by adults

Legally and ethically, any adult with capacity has the right to refuse any medical treatment, even if that refusal will result in their death. If the patient declares that they do not wish to be resuscitated then this should be thoroughly documented in the patient’s notes and communicated effectively to all who need to know. The patient is not obliged to justify the decision, but clarification of why the decision has been made is desirable to ensure it has not been reached in error or through misunderstanding. Unless these records are signed by the patient, and the signature is witnessed, they are unlikely to meet the legal criteria for advanced decisions (see: Advanced Decisions to
Refuse Treatment Policy OP25). If the patient is not currently receiving treatment and wishes their decision to be respected then they may make a formal written advance decision. The criteria for doing so is stipulated in the Mental Capacity Act 2005, and the onus is on the patient to ensure the healthcare provider is aware of the terms and content of any decision.

6.4.1 Advance decisions refusing resuscitation. CPR must not be attempted if it goes against any valid advance decision made when the patient had capacity. In England and Wales, advance decisions are governed by the Mental Capacity Act 2005. This provides that advance decisions refusing CPR will be valid and legally binding on the healthcare team if:
- The patient was 18 years old or over and had capacity when the decision was made.
- The decision is in writing and has been signed and witnessed.
- It includes a statement that the advance decision is to apply even if the patient’s life is at risk.
- The advance decision has not been withdrawn
- The patient has not, since the advance decision has been made, appointed a welfare attorney to make decisions about CPR on their behalf.
- The patient has not done anything clearly inconsistent with the terms of the advance decision.
- The circumstances that have arisen match those envisaged in the advanced decision.

6.5 Advanced care planning
Healthcare professionals have an important role in helping patients to participate in making appropriate plans for their future care. This must be done in a sensitive but honest manner, making it as clear as possible how realistic a resuscitation attempt would be. If a DNR order would be the most appropriate course of action this should be explained to the patient clearly and sensitively.

For many patients receiving care, the likelihood of cardiorespiratory arrest is small and no clinical decision is made in advance of such an event. There is no ethical or legal requirement to discuss every possible eventuality with all patients and if the risk of cardiorespiratory arrest is considered very low it is not necessary to initiate discussion about CPR with the patient, or with those close to or representing patients who lack capacity. If cardiorespiratory arrest does occur unexpectedly, CPR should be attempted in accordance with the advice in these guidelines. (see section 6.1: Presumption in favour of CPR)

6.5.1 Advance decisions on resuscitation attempt duration
If a member of the Trust is involved in assisting patients prepare an advance decision, any restrictions on the duration of CPR or resuscitation attempts are to be avoided wherever possible. In ordinary circumstances and where there is no advance decision, the duration of resuscitation attempts should be decided upon by the resuscitation team based upon the clinical circumstances in existence at the time of the arrest.
6.5.2 Restriction in CPR treatment.
Restriction of CPR treatment to shockable rhythms only may be considered by clinicians in some clinical areas. If this action is decided then the full nature and extent of CPR for the individual should be clearly documented and communicated, along with a clear rationale for the decision.

6.6 Verification of expected death
All patients where consultant staff have requested that nurses follow verification of expected death procedures must have a current DNR order in existence.

6.7 Recording DNR decisions
The completion of a DNR form does not replace the need for thorough documentation in the patient’s notes. The most senior member of the medical team available should complete a detailed entry in the patient’s notes giving dates, times, rationale and details of any discussions with patients, family, carers and colleagues. If addressographs are used they must be applied to BOTH copies of the DNR form.

Any decisions about attempting CPR should be easily accessible to all healthcare professionals involved in the patients care. DNR forms are produced in duplicate and guidance on completing them is printed on the reverse of them. The top copy of the form (with a red border) must be attached to the inside front cover of the current volume of the patient’s medical notes.

6.8 Review of DNR orders
DNR orders are indefinite by default. The clinician documenting this decision should give careful consideration to the need for a review date. If any doubt exists then an appropriate review date should be applied. When the DNR order reaches this date it is no longer valid. If the patient was to have a cardiopulmonary arrest after this review date then cardiopulmonary resuscitation would normally be attempted.

6.8.1 Expired or cancelled DNR orders should be detached from the front inside cover of the current medical notes, crossed through, and labelled as “CANCELLED”, signed and dated, then stored in the back of the medical notes.

6.8.2 All DNR orders should be reviewed if any change in the patient’s condition is evident that may have effect upon the likelihood of a successful CPR attempt. The order should be reviewed if the patient is transferred from one healthcare institution to another, admitted from home, or discharged home.

6.8.3 Clinicians should review the suitability of any indefinite DNR order, and revoke or cancel it if any suitable change in circumstance is evident. The person who makes a CPR decision is responsible for ensuring that the decision is communicated effectively to other relevant healthcare providers involved in that patient’s care.
6.8.4 If a patient with a valid DNR order requires transportation by the ambulance service, the North East Ambulance Service NHS Trust DNR Patient Transport policy should be followed for booking transportation. This can be found in the Policies and Guidelines section of the Resuscitation Intranet page, (http://www/departments/resuscitation/policies.html).

6.9 Confidentiality

Patient with capacity have a right to have their healthcare decisions and information kept confidential. Accordingly, they have the right to decide who is and who is not to know about their care. If a patient is made subject to a DNR Order, it would be beneficial if, at the time that the patient’s status is changed to DNR, the patient’s wishes with regard to who is to be informed of their DNR status were also obtained. These should be clearly recorded in the patient’s records to avoid any accidental disclosures to family or friends that do not accord with the patient’s wishes. If the patient’s wishes are for their DNR status to not be disclosed to their family or friends then it shall not be disclosed by clinicians delivering care to the patient.

If the patient lacks capacity and their views on the disclosure of information relating to their care are not known, it is acceptable for carers to disclose confidential information in order to help in establishing the patient’s views and wishes. If a guardian or deputy is involved the carer should give them enough information to fulfilling their role. If an MCA is involved, they have a legal right to receive information about the patient, including access to the relevant parts of the patient’s records, in order to enable them to properly perform their role.

6.10 Information for patients

Written literature about resuscitation and not attempting resuscitation is available throughout the Trust. A patient information leaflet produced by the BMA has been amended for local use; this can be accessed on the Resuscitation Department intranet page or by contacting the Resuscitation Officers through switchboard. This information leaflet should be made freely available to patients and visitors who require or request it.

7. Training.
CPR should be performed competently and in line with current national guidelines as taught in yearly mandatory training. Completion of the DNR orders is an integral part of CPR teaching sessions and is taught at all sessions within the organisation.

8. Equality and Diversity
The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.
9. Monitoring compliance/effectiveness of the policy

Clinical practice with regard to this DNR policy is audited annually within the Trust. Audit activity is carried out jointly between the Resuscitation Officers and the Safecare Department. Audit outcomes are presented to the Resuscitation Committee and Safecare.

10. Consultation and Review

The Resuscitation Committee is responsible for the timely review of this policy. Reviews will be commenced four months prior to the planned date that the policy lapses, as this will ensure that a Resuscitation Committee quarterly meeting will review every policy change. This policy has been compiled and reviewed by the Resuscitation Committee taking guidance from the Resuscitation Council (UK) document recommended standards for recording DNAR decisions (2009).

11. Implementation of policy and raising awareness

This policy has been compiled in compliance with OP27 – Policy for the development, management and authorisation of policies and procedures.

12 References

Resuscitation Council (UK) http://www.resus.org.uk/pages/DNARrstd.htm [Internet Reference, accessed 20:07:09]

13. Associated documentation

Operational Policy 25 – Advance decisions to refuse treatment policy.
Appendix 1
Do Not Resuscitate Order Form

Note: The following four pages are examples of the adult DNR form. The form is printed in duplicate. Whilst the front two pages are practically identical, the back of those pages are different. The back of the top copy (for the patients’ notes) displays a decision making framework, whilst the back of the duplicate copy (to forward to the Resuscitation Officer) shows instructions for completing the form.
Adults aged 16 years and over

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<td>Address</td>
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<tr>
<td>Date of birth</td>
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<td>NHS or hospital number</td>
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In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the patient have capacity to make and communicate decisions about CPR?  
   - If "YES" go to box 2
   - If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?  
     - If "YES" go to box 6
   - If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf?  
     - If "YES" they must be consulted.

   All other decisions must be made in the patient’s best interests and comply with current law. Go to box 2

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

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

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

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

6. Healthcare professional completing this DNAR order:

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<th>Name</th>
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7. Review and endorsement by most senior health professional:

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<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>Review date (if appropriate)</td>
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If a review date is set and this date passes, then a new DNR form should be completed if the decision still stands.
**DECISION-MAKING FRAMEWORK**

- **Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?**
  - Yes
  - **NO**

- **Is there a realistic chance that CPR could be successful?**
  - Yes
  - **NO**

- **Does the patient lack capacity and have an advance decision refusing CPR, or a welfare attorney with suitable authority?**
  - Yes
  - **NO**

  - **Are the potential risks and burdens of CPR considered to be greater than the likely benefits of CPR?**
    - Yes
    - **NO**

  - **CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.**

  - **If there is no reason to believe a patient is likely to have a cardiorespiratory arrest then it is not necessary to initiate discussion about CPR with the patient, or those close to the patient who lacks capacity. But if the patient wishes to discuss CPR this should be respected.**

  - **When a decision not to attempt CPR is made on these clear clinical grounds, it may not be appropriate to ask the patient’s wishes about CPR. Consideration should be given to inform the patient and guidance is found in section 6.2 of policy RM27b. Where the patient lacks capacity and has a welfare attorney or court appointed deputy or guardian, this person should be informed of the decision not to attempt CPR and the reasons for this. If a second opinion is requested it should be respected.**

  - **If a patient has made an advance decision refusing CPR, and the criteria for validity are met, this must be respected. If an attorney, deputy or guardian has been appointed they must be consulted (see section 6.2.3 of policy RM27b).**

  - **When there is only a small chance of success, and there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or those appropriate if the patient lacks mental capacity) in making the decision is crucial. If the patient is a child, those with parental responsibility should be involved in the decision where appropriate. When adult patient’s have mental capacity their own view should guide the decision-making (see section 6.2 of policy RM27b).**

- **Decisions about CPR are sensitive and complex. They should be undertaken by the most senior, experienced clinician involved in the patients care and documented thoroughly.**
- **Decisions should be reviewed regularly, as and when circumstances change.**
- **Advice should be sought if there is any doubt or uncertainty.**
In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the patient have capacity to make and communicate decisions about CPR?  
   If “YES” go to box 2

   If “NO”, are you aware of a valid advance decision refusing CPR which is relevant to the current condition?  
   If “YES” go to box 6

   If “NO”, has the patient appointed a Welfare Attorney to make decisions on their behalf?  
   If “YES” they must be consulted.

   All other decisions must be made in the patient’s best interests and comply with current law.  
   Go to box 2

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

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

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

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

6. Healthcare professional completing this DNAR order:

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<td>Signature</td>
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7. Review and endorsement by most senior health professional:

   | Signature | Review date (if appropriate) | Name | Date |

   If a review date is set and this date passes, then a new DNR form should be completed if the decision still stands.
This ADULT DNR form should be completed in black ball point ink
All sections should be completed

- The patient’s full name, date of birth and address should be written clearly.
- The date of writing the order should be entered.
- This order will be regarded as “INDEFINITE” unless it is clearly cancelled or a definite review date is specified.
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. **Capacity / advance decisions**
   Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient’s current circumstances.
   *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.*

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

3. **Summary of communication with patient...**
   State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate.

4. **Summary of communication with patient’s relatives or friends**
   If the patient does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A 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 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 where appropriate.

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

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

7. **Endorsement / review...**
   The decision must be endorsed by the most senior healthcare professional responsible for the patient’s care at the earliest opportunity.
In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the child have capacity to make and communicate decisions about CPR?
   If “YES” go to 1b. If “NO” go to 1c.

1b. Has the child been involved in the decision making process of this order?
    Now go to 1c.

1c. Have the child’s parents (or those holding legal parental responsibility) been consulted and agreed to the application of this order? If “YES” go to box 2.

1d. Has a Court made an order in respect of this decision? If “YES” go to 1e.

If the answers to both 1c and 1d are “NO”, legal advice must be taken before proceeding. All other decisions must be made in the child’s best interests and comply with current law.

1e. Date, time, location and name of Judge/Court making order:

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

3. Summary of communication with child. If this decision has not been discussed with the child state the reason why:

4. Name of person(s) holding parental responsibility and summary of communication with them:

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

6. Healthcare professional completing this DNAR order:

   Name
   Position
   Signature
   Date
   Time

7. Review and endorsement by most senior health professional:

   Signature
   Name
   Date

Review date (if appropriate)

If a review date is set and this date passes, then a new DNR form should be completed if the decision still stands.
This PAEDIATRIC form should be completed in black ball point ink
All sections should be completed

- The patient's full name, date of birth and address should be written clearly.
- The date of writing the order must be recorded.
- **This order will be regarded as “INDEFINITE” unless it is clearly cancelled or indefinite review date is specified.**
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. **Child’s capacity: Parental responsibility and decisions**
   - Record the assessment (using Fraser guidelines) of the child’s capacity in the clinical notes.
   - If the child is noted to have capacity but not included in the decision process a detailed, reasoned explanation for this decision should be included in the clinical notes and summarised in section 3.
   - Record all discussions with those holding parental responsibility in the notes. Document all action points discussed with a clear indication of the absence or presence of parental agreement. Any disagreements that cannot be resolved should be discussed with your Trust’s legal department for advice before completing this order.
   - Record all communications with the courts.
   - The date, time and name of the Court must be recorded in section 1e where the Court has been involved or made a formal ruling on the application of this Order. A copy of the order should be filed in the patient's health record.

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

3. **Summary of communication with child**
   If this decision was not discussed with a child with capacity summarise the reason why this was inappropriate (Full detail should be recorded in the clinical notes). Otherwise state clearly what was discussed and agreed.

4. **Summary of communication with persons holding parental responsibility**
   Whether or not the child has capacity their legal guardians (i.e. persons with parental responsibility) must be consulted. If the child has capacity and has been consulted great care must be taken to ensure that discussions do not compromise the clinician-child relationship. If the child and their guardians are not in agreement a legal opinion should be sought.
   State the names and relationships of guardians with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

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

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

7. **Review / endorsement ...**
   The decision should be discussed with and endorsed by the most senior healthcare professional responsible for the child's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.