# Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] Policy

**Reference Number:**

NHSCT/12/562

**Target audience:**

This policy applies to hospital and community inpatient facilities and is directed to medical staff and other members of the multidisciplinary team who are involved in the process of making, recording and reviewing DNACPR orders.

**Sources of advice in relation to this document:**

Hazel Baird, Head of Governance & Patient Safety  
Padraig Dougan, Resuscitation Officer  
Adam Hanna, Resuscitation Officer

**Replaces (if appropriate):**

Legacy Causeway and United’s Resuscitation Policies and NHSCT Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy (NHSCT/12/525)

**Type of Document:**

Trust Wide

**Approved by:**

Policy, Standards and Guidelines Committee – 17 May 2012  
Dr Peter Flanagan – Updated Version – 4 July 2012

**Date Issued by Policy Unit:**

4 July 2012

**NHSCT Mission Statement**

To provide for all the quality of services we would expect for our families and ourselves
Northern Health and Social Care Trust

‘Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)’
Policy

(to be read in conjunction with the NHSCT Resuscitation Policy)
‘Do Not Attempt Cardiopulmonary Resuscitation’ Policy

1.0 Introduction to Policy

1.1 Cardiopulmonary Resuscitation (CPR) is a procedure which can be initiated on any patient who has stopped breathing and is pulseless. However the absence of breathing and pulses is part of the normal process of dying and it would be inappropriate to initiate CPR in all patients who are not breathing and pulseless. It is therefore necessary to identify patients in whom CPR would be inappropriate and to facilitate a dignified end to the natural process of dying which is often the only outcome of their illness or disease.

1.2 It is also essential to identify those patients who would not want CPR to be attempted in the event of a cardiopulmonary arrest (sudden and unexpected collapse and their breathing and heart stop) and who have the mental capacity to refuse this treatment option, including those who may have made a valid advance decision (Advance Directive or Living Will - see point 11.3).

1.3 Where no explicit decision has been made about resuscitation before a cardiopulmonary arrest and the express wishes of a patient are unknown, staff will attempt to resuscitate the patient.

1.4 Throughout this policy the term ‘relevant others’ is used to describe relatives, carers, representatives, advocates, etc.

2.0 Purpose of Policy

2.1 The purpose of this policy is to provide guidance for all relevant staff working within the Northern Health and Social Care Trust regarding the process of making, recording and reviewing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

3.0 Policy statement

3.1 It is policy that CPR should be attempted on every person (patient/visitor/staff) who suffers a cardiopulmonary arrest in any of the Northern Health and Social Care Trust premises, unless written, signed instructions exist stating that active resuscitation is inappropriate for that person.

4.0 Target audience

4.1 This policy applies to hospital and community inpatient facilities and is directed to medical staff and other members of the multidisciplinary team who are involved in the process of making, recording and reviewing DNACPR orders.
5.0 **Legislative compliance/Policy context**

5.1 The policy should be read in conjunction with the following documents:

- Decisions relating to cardiopulmonary resuscitation: A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007.

- Northern Trust Policy on Consent for Examination, Treatment or Care, April 2009, which provides guidance on issues concerning capacity to consent and best interest principles.

6.0 **Responsibilities**

6.1 **Directors** are responsible for ensuring that the policy is disseminated and implemented and used in the appropriate clinical areas across their directorate.

6.2 **Consultants** are responsible for promoting best practice in line with this policy within the medical team.

6.3 The **Medical Director** has responsibility for ensuring that compliance with the policy is subject to regular audit.

7.0 **Policy objectives**

- to ensure that DNACPR decisions are made in keeping with current national guidelines
- to avoid inappropriate resuscitation
- to make DNACPR decisions transparent and open to examination
- to encourage appropriate and realistic discussion with patients and their relevant others about resuscitation issues
- to ensure that patients, relevant others and staff have information on making decisions about resuscitation and that they understand the process
- to ensure that decisions regarding CPR are made according to the patient’s wishes
- to clarify that patients and relevant others will not be asked to decide about CPR when it would clearly fail and therefore is not a treatment option, or when the circumstances of a possible arrest cannot be anticipated and therefore informed discussion cannot take place
- to ensure that a DNACPR decision is clearly documented and communicated to all the relevant healthcare professionals and services involved in the patient’s care
- to ensure that DNACPR decisions are reviewed appropriately.
8.0 DNACPR

8.1 The term ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) indicates that in the event of cardiopulmonary arrest neither basic nor advanced resuscitation will be instigated.

8.2 A DNACPR decision applies solely to CPR; simple basic first aid will still be instigated as appropriate (e.g. placing the patient in the recovery position, clearing the airway of food or vomit, etc). Other treatment will not be influenced by a DNACPR decision.

8.3 A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the patient’s respiratory or cardiac arrest that does not match the circumstances envisaged.

8.4 A DNACPR decision must be recorded in the patient’s medical notes and signed by a senior clinician and/or their deputy.

8.5 DNACPR orders must be made in conformity with this policy, which includes the completion of a Trust DNACPR form (Appendix 3 or 4 depending on the age of the patient).

8.6 Because of the nature of the interventions in the Intensive Care Unit (ICU) setting, decisions there regarding resuscitation will usually be made in conjunction with decisions concerning withdrawal or limitation of supportive therapy. Therefore, an ICU-specific procedure is required. The Trust has adopted CCaNNI ‘Guideline for End of Life Care’ (January 2009) and will use a specific Trust proforma ‘Procedure for Withdrawal or Limitation of Treatment’ (Appendix 1).

8.7 Where a DNACPR order is in place and a patient has an Implantable Cardioverter Defibrillator (ICD) in situ, timely arrangements should be made for it to be deactivated by contacting Antrim or Causeway Cardiac Investigations Department.

9.0 Involvement of adult patients

9.1 Competent patients should be involved in discussions about attempting CPR unless they indicate that they do not want to be. A competent adult’s decision to refuse CPR must be respected. Neither patients nor those close to them can demand treatment that is clinically inappropriate.

9.2 A DNACPR decision will usually only be made after discussion with the patient and/or their relevant others. Any discussion with the patient or their relevant others regarding resuscitation must be documented on the appropriate Trust DNACPR form.

9.3 Patients may be offered relevant written information regarding resuscitation and the meaning of DNACPR as appropriate – see Appendix 2. To access this information sheet either click the link Resuscitation and the DNACPR decision: Information for
patients and carers or print off a copy from Staffnet by selecting Business Areas and then Resuscitation Service.

9.4 It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer cardiopulmonary arrest. If, however, a patient does require CPR and the outcome is successful, discussions about the possibility of future resuscitation should take place, if appropriate.

9.5 If the discussions about resuscitation would be unnecessarily burdensome for the patient or they do not have capacity to make decisions, the decision not to resuscitate shall be made using a multi-disciplinary team approach, with the best interests of the patient as the only objective. The views of any relevant others should be taken into account, where possible. However, it must be understood that, in the case of an adult, no other person apart from the patient can give or refuse consent to treatment.

9.6 The overall responsibility for decision-making rests with the consultant/general practitioner in charge of the individual patient’s care. In the absence of the treating consultant/general practitioner, an appointed medical deputy may make decisions.

9.7 In palliative care or where attempted CPR is likely to be futile, any discussion with the patient and/or their relevant others may primarily be about allowing a natural death and clinicians explaining that resuscitation is unlikely to work or be of benefit.

9.8 In circumstances in which it is not possible or appropriate to discuss CPR with a patient and/or their relevant others, the DNACPR form must still be completed indicating the reasons why these discussions were not appropriate.

10.0 Children and young people

10.1 Decisions not to attempt to resuscitate children and young people will be infrequent and will usually be taken as part of an end-of-life plan.

10.2 Clinical decisions relating to resuscitation of children and young persons ideally should be taken within a supportive partnership involving patients, their families and the health and social care team. Where appropriate, the views of children and young people should be taken into consideration in decisions about attempting CPR. Medical involvement in this process must always be at consultant level.

10.3 The DNACPR form for children less than 16 years of age (Appendix 3) should be completed summarising the reasons why CPR would be inappropriate, who all contributed to this decision and any discussions which took place with the child and the person(s) with parental responsibility. Guidance for completion can be found on the back of the form.

10.4 For further guidance, refer to the Trust Policy on Consent for Examination, Treatment or Care Appendix 3 section 4.
11.0 **DNACPR decision-making**

11.1 A decision that CPR will not be attempted, on best interest grounds because the burdens outweigh the benefits should be made only after consideration of all relevant factors.

11.2 Factors influencing a decision not to attempt resuscitation should include:

- the likely clinical outcome, including the likelihood of successfully restarting the patient's heart and breathing and the level of recovery that can realistically be expected after successful resuscitation
- the burden of resuscitation outweighs any possible benefit
- death is expected imminently as a natural progression of the disease process
- where resuscitation is not in accord with a valid and applicable advance directive
- where resuscitation is not in accord with the patient's known or ascertainable wishes or their previously expressed views, feelings, beliefs and values.

11.3 Should a patient be unable to make their wishes known, a valid advance directive (i.e. an anticipatory refusal or 'living will', giving informed and competently made instructions that relates to the circumstances which have arisen,) is likely to be legally binding. Some patients choose to express their wishes in a written document but it is not necessary for refusal to be in writing in order to be valid. Where a competent patient has expressed a clear and consistent refusal, this is likely to have the same status as a written advance directive.

12.0 **Discussions with patients and/or relevant others about DNACPR**

12.1 Discussions about resuscitation are sensitive and complex and should be undertaken by experienced medical or nursing staff.

12.2 The timing and nature of discussions about resuscitation are a matter of judgement for the clinical team. Such discussions can result in upset and even anger for patients and their families and are often uncomfortable for healthcare staff but anticipation of this should not prevent open and honest communication.

12.3 Information should be provided in a manner and format which the patient understands; this may include the need for an interpreter.

12.4 The main purpose of discussions is to elicit what the patient’s views are or would be if they were able to express them.

12.5 Issues for discussion may include:

- the nature of the patient’s illness(es), including burden of disease
- the likely course of the underlying illness(es) and prognosis for life and distress/pain
• the therapeutic options in the absence of a DNACPR order
• the likely outcome and course of attempted resuscitation including intubation, ventilation, the possibility of successful outcomes etc
• a recognition that at times it is better not to intervene and that DNACPR is not unethical.

13.0 Recording a DNACPR decision

13.1 Attempted resuscitation will be commenced on all patients undergoing cardiopulmonary arrest unless a DNACPR order is recorded. A decision not to resuscitate must be recorded in the medical notes as soon as possible after admission, stating the reasons for the decision. If the patient was not consulted this should also be recorded, together with the reasons for not having done so. Specific forms are available for recording DNACPR decisions.

13.2 The DNACPR decision must be recorded on a Trust DNACPR form (see Appendices 3 and 4 for sample forms). After the form is completed it must be filed inside the front cover of the patient’s current medical notes with a brief reference in the current admission notes, using dark ink and capitals. Guidance for completion can be found on the back of the form.

13.3 The resuscitation decision will be recorded in the nursing care plan by the nurse to whom the DNACPR decision has been communicated.

13.4 In circumstances where the DNACPR order is made by the most senior doctor immediately available, it should be reviewed and endorsed by the consultant or general practitioner responsible for the patient’s care as soon as possible.

13.5 When a DNACPR order is in place for the patient, this should be made known when there is a change of care provider.

14.0 Review of a DNACPR decision

14.1 A completed DNACPR form in the medical records is to be regarded by all staff as the current authoritative statement. It is therefore imperative that this record is reviewed and kept up-to-date.

14.2 The DNACPR order must be reviewed, at an interval which is appropriate in the individual case, and particularly if there is a significant change in the clinical condition of the patient. Reviews should be recorded on the DNACPR form.

14.3 When a DNACPR order is cancelled, the form should be lined-through in ball-point pen with two diagonal lines and the word CANCELLED written clearly between them. The review section should be signed and dated by the member of the medical team cancelling the order. The reasons for reversal of the decision should be recorded in the patient’s records and the DNACPR form removed from the inside front cover and filed in the body of the notes.
14.4 The clinician making or cancelling a DNACPR order is responsible for ensuring that a trained member of the nursing team on the current shift is informed. That nurse must acknowledge this by recording the decision to cancel the DNACPR in the care plan. It is the responsibility of that nurse to make known the resuscitation status of the patient to staff taking over their care, and the reasons for that decision.

15.0 **Transfer to another hospital within the Trust or to a residential or nursing home.**

15.1 A current DNACPR order will not automatically be revoked on patients transferred to another hospital within the Trust. It will be the responsibility of the admitting doctor to review the decision. For emergency referrals, the initial decision will be made by the admitting doctor following consultation with the ward team, the referring doctor and the patient (or their next-of-kin if the patient is unable to make their wishes known) and confirmed with the responsible senior doctor at the next ward round.

15.2 For transfer of patients to a Trust community hospital or Trust residential unit, the discharge summary should indicate that there was a valid DNACPR order in place in hospital and request that the decision is reviewed at the earliest opportunity by the GP, the multidisciplinary team and the patient and/or their next-of-kin if it is not appropriate to involve the patient. However, where documentation accompanying the patient indicates that discussion regarding resuscitation has taken place with the patient and/or their family then the admitting nurse or senior care worker can ascertain if their wishes regarding resuscitation remain unchanged until review by the GP can take place. If staff have any concerns regarding the patient’s resuscitation status prior to review by the GP, he/she should contact them or the out-of-hours doctor for guidance.

15.3 When patients who have had a DNACPR order in hospital are being transferred to a nursing home, this information should be notified to the staff in the transfer documentation. It is the responsibility of the GP who is taking over the patient’s medical care to review the DNACPR.

16.0 **Ambulance transportation**

Where a patient with a DNACPR order is to be transferred via the Northern Ireland Ambulance Service (NIAS), this should be made clear to NIAS at the time of booking. Should the DNACPR status of the patient change prior to transportation, then NIAS must be informed of this change at the earliest convenience. A DNACPR Transport form (Appendix 5) must be completed by medical and nursing staff to be given to the collecting representative from NIAS. A copy of this form can be printed off from StaffNet by selecting Business Area and then, Resuscitation Service or by selecting the link above.
17.0 **Equality, Human Rights and DDA**

The policy is purely clinical/technical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

18.0 **Alternative formats**

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

19.0 **Sources of advice in relation to this document**

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

20.0 **References**

Decisions Relating to Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007.


Guideline for End of Life Care: Critical Care Network Northern Ireland, January 2009.


Policy on Consent for Examination, Treatment or Care, Northern Health and Social Care Trust, April 2009.


Withholding and Withdrawing Life-Prolonging Treatments: General Medical Council, August 2002.

Treatment and care towards the end of life: good practice in decision making: General Medical Council, May 2010
Appendix 1

NORTHERN HEALTH AND SOCIAL CARE TRUST
INTENSIVE CARE UNIT, ANTRIM HOSPITAL / CAUSEWAY HOSPITAL

PROCEDURE FOR WITHDRAWAL OR LIMITATION OF TREATMENT

This form is to be filed in the patients chart. Please read the notes overleaf.

Given the current clinical status and response to therapy, the decision of the Clinical Teams is that:

1) **Supportive Therapy Be Withdrawn**
   - cessation of inotropes/pressors, antibiotics, mechanical ventilatory support
   Discussed with: patient/ family / surrogate decision maker (delete as appropriate)

Has the potential for organ donation been discussed with the Organ Donation team prior to withdrawal of treatment?  Yes / No

Sign and print name: ________________________________ Consultant, Intensive Care
Sign and print name: ________________________________ Consultant, Intensive Care
Date:___________________                      Time:___________________

2) **Supportive Therapy Be Limited** (enter limits below)

   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

Sign and print name: ________________________________ Consultant, Intensive Care Unit
Comments:_____________________________________________________________________________________
Date:___________________                      Time:___________________

**** The status of this decision should be reviewed daily: see reverse of form ****

3) **Resuscitation in the event of a cardiac arrest**
   1) ______ No resuscitation: No defibrillation, no chest compressions, stop ventilation.
   2) ______ Full resuscitation

Sign and print name:__________________________________________ Consultant, Intensive Care Unit
Date:___________________                      Time:___________________

11
INTENSIVE CARE UNIT ANTRIM HOSPITAL / CAUSEWAY HOSPITAL

PROCEDURE FOR WITHDRAWAL OR LIMITATION OF THERAPY

1) The decision to limit therapy or to withdraw therapy is to be made at consultant level only.
2) Prior discussion should take place between the Intensive Care Consultant and the referring consultant responsible for the patient before withdrawal of therapy.
3) Prior discussion should take place between the Intensive Care Consultant and the patient (if competent) or their surrogate decision maker/family before withdrawal of therapy.
4) Withdrawal of therapy is appropriate where continued aggressive treatment is futile, or where a competent patient refuses continued treatment.
5) Discuss the potential for Organ donation with the Organ donation Team prior to withdrawal of treatment.
6) Limitation of therapy is appropriate in cases where it is warranted given the current condition of the patient, but where escalation of treatment in the face of clinical deterioration is futile.
7) Consultant staff should ensure that this form is completed after any decision on limitation or withdrawal of therapy is made, and that all relevant staff are aware of the instructions.
8) It is recognized that limitation of therapy or formal Do Not Resuscitate orders may have to be implemented “out of hours”, However, where possible, withdrawal of therapy should occur during daylight hours.

Review of decision to limit / withdraw therapy: to be completed daily by ICU Consultant

Date: ________________________                       Time: ______________________
___    The decision as indicated overleaf remains in force
    OR
___    The decision as indicated overleaf has been altered, and a new form completed
    OR
___    The decision as indicated overleaf has been withdrawn

Sign and print name: _____________________________________

Date: ________________________                       Time: ______________________
___    The decision as indicated overleaf remains in force
    OR
___    The decision as indicated overleaf has been altered, and a new form completed
    OR
___    The decision as indicated overleaf has been withdrawn

Sign and print name: _____________________________________

Date: ________________________                       Time: ______________________
___    The decision as indicated overleaf remains in force
    OR
___    The decision as indicated overleaf has been altered, and a new form completed
    OR
___    The decision as indicated overleaf has been withdrawn

Sign and print name: _____________________________________
Appendix 2

Resuscitation and the ‘Do Not Attempt Cardiopulmonary Resuscitation’ decision: Information for patients and carers

What is resuscitation?

Should a patient in hospital suddenly and unexpectedly collapse and their breathing and heart stop, this is known as a cardiac arrest. The hospital staff are taught how to carry out resuscitation. Resuscitation is sometimes abbreviated as ‘CPR’ (Cardiopulmonary Resuscitation).

What does resuscitation involve?

Resuscitation may involve the following:

- Regular pressing on the front of the chest
- Putting needles into the arms and neck to give injections
- Helping breathing by a mask or a tube placed down the person’s throat
- Electric shocks given to the front of the chest to try and restart the heart
- Moving by ambulance to a larger hospital for further treatment.

Does resuscitation always work?

Resuscitation is rarely needed. Unfortunately, it often does not work and only a small number of people (about 2 in 10) survive. The chances of success depend partly on how well the patient was beforehand. There are certain illnesses which reduce the chances of survival after resuscitation. Ask your doctor, if you are concerned. He/she will be able to give you more information about your particular circumstances.

What is a ‘Do Not Attempt Cardiopulmonary Resuscitation’ order?

Do Not Attempt Cardiopulmonary Resuscitation is often abbreviated as ‘DNACPR’. A ‘DNACPR’ order is put in a patient’s case notes when the patient has asked not to be resuscitated, when the doctors feel that there is no chance of resuscitation working because of the patient’s underlying illness or when the burden of resuscitation would outweigh possible benefits.

Who decides when to use a DNACPR order?

The DNACPR decision normally would be taken by a consultant/senior doctor in consultation with:

- The patient
- Other members of the multidisciplinary team
- The patient’s family or carer - if a patient is unable to say whether or not they wish to have a DNACPR order, the doctor may ask their family or carer to say what they think the patient would have decided.

Does a DNACPR order affect other medical treatments?

A DNACPR order refers only to resuscitation if the heart and breathing stops. It does not apply to or alter any other medical treatment or nursing care. A patient with a DNACPR order in their notes will still receive all of the other treatments that they might need while they are in hospital.

What should I do now?

A hospital doctor or nurse involved in managing your care will be able to let you know more about resuscitation and DNACPR orders. You will be able to discuss this with your doctor early in your hospital stay. You may wish to ask other members of your family before you decide. If you have any questions about the issues raised in this leaflet, please ask one of the nursing staff or doctors for some further information.

Can I change my mind?

All resuscitation decisions are reviewed regularly and you can change your mind at any time. You must let your ward doctor know if you change your mind so that your decision can be changed in your case notes.
## DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Children less than 16 years of age

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Address</th>
<th>Hospital</th>
<th>Hosp No.</th>
<th>Consultant</th>
<th>Ward/Dept.</th>
</tr>
</thead>
</table>

Date of DNACPR order: [ / / ]

**DO NOT PHOTOCOPY**

---

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

<table>
<thead>
<tr>
<th>1a.</th>
<th>YES / NO</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1b.</th>
<th>YES / NO</th>
</tr>
</thead>
</table>

### 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.

<table>
<thead>
<tr>
<th>1c.</th>
<th>YES / NO</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1d.</th>
<th>YES / NO</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>YES / NO</th>
</tr>
</thead>
</table>

---

### 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 and positions of members of multidisciplinary team contributing to this decision:

---

### 6. Healthcare professional making this DNACPR order:

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

Signature [ ]  Date [ ]  Time [ ]

---

### 7. Review and endorsement by most senior health professional:

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

Review when clinically appropriate.  To cancel, put 2 diagonal lines through page and write CANCELLED between lines, sign below and document reason decision reversed in patient’s records.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>
Appendix 3

Children less than 16 years of age

This form should be completed legibly 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.
- 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 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 DNACPR order has been communicated to all relevant members of the healthcare team.

6. Healthcare professional completing this DNACPR 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.
# DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

**Adults aged 16 years and over**

<table>
<thead>
<tr>
<th>Name _______________________</th>
<th>DOB ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address ____________________</td>
<td></td>
</tr>
<tr>
<td>Hospital ____________________</td>
<td>Hosp No. __________________</td>
</tr>
<tr>
<td>Consultant _________________</td>
<td>Ward/Dept. ________________</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Does the patient have capacity to make and communicate decisions about CPR?</strong>&lt;br&gt;Yes/No&lt;br&gt;If &quot;YES&quot; go to box 2&lt;br&gt;If &quot;NO&quot;, are you aware of a valid advance decision refusing CPR which is relevant to the current condition?&quot; If &quot;YES&quot; go to box 6&lt;br&gt;All other decisions must be made in the patient’s best interests and comply with current law. Go to box 2</td>
</tr>
<tr>
<td>2</td>
<td><strong>Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:</strong></td>
</tr>
<tr>
<td>3</td>
<td><strong>Summary of communication with patient. If this decision has not been discussed with the patient state the reason why:</strong></td>
</tr>
<tr>
<td>4</td>
<td><strong>Summary of communication with patient’s relatives or friends:</strong></td>
</tr>
<tr>
<td>5</td>
<td><strong>Names and positions of members of multidisciplinary team contributing to this decision:</strong></td>
</tr>
<tr>
<td>6</td>
<td><strong>Healthcare professional completing this DNACPR order:</strong>&lt;br&gt;Name _______________________</td>
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<tr>
<td></td>
<td>Signature ___________________</td>
</tr>
<tr>
<td>7</td>
<td><strong>Review and endorsement by most senior health professional:</strong>&lt;br&gt;Signature ___________________</td>
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</tbody>
</table>

Review when clinically appropriate. To cancel, put 2 diagonal lines through page and write CANCELLED between lines, sign below and document reason decision reversed in patient’s records.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
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</table>
Adults aged 16 years and over

This form should be completed legibly 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.
- 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 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.

   **16 and 17-year-olds:** Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

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

3. **Summary of communication with patient...**
   State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate. It is not essential to discuss CPR with every patient. If a patient is in the final stages of a terminal illness and discussion would cause distress without any likelihood of benefit this situation should be recorded.

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 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 DNACPR order has been communicated to all relevant members of the healthcare team.

6. **Healthcare professional completing this DNACPR 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 must be endorsed by the most senior healthcare professional responsible for the patient’s care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.
Appendix 5

SAMPLE FORM

RESUSCITATION STATUS ADVISORY
DO NOT ATTEMPT CPR

To: Northern Ireland Ambulance Service Crews  NIAS Booking ref:

Patient Name: - ______________________________________________________

Date of Birth: - _______________________________________________________

Address: - ________________________________________________________________________

Destination Address: - _______________________________________________________________________(if different from above)

GP: - ________________________________________________________________________________

Because of advanced disease status it is now not appropriate to perform CPR or Advanced Life Support on the above patient if they suffer a cardiac or respiratory arrest whilst being transported in your vehicle.

The above patient has a non-reversible condition and it is the opinion of their multi-professional team that cardiopulmonary resuscitation measures would not be in their best interest. All other appropriate treatment and care must be provided.

If death should occur before arriving at your destination, please call hospital staff on the telephone number below to discuss management of the deceased. Do not automatically take the deceased to the nearest Emergency Department. This form must be attached to the relevant NIAS PRF for return to NIAS Audit Department.

Authorising Clinician

Signed........................................................................... (Consultant/Registrar)

Name (print).................................................................

Position ........................................................................

Date ...........................................................................

Second Authorisation (Sister / Charge Nurse / Deputy)

Signed........................................................................

Name (print) .................................................................

Position ........................................................................

Date ...........................................................................

Telephone Number ........................................... (ext)..............

Supported by the following Northern Ireland Health & Social Care Trusts:
Belfast, Northern, South Eastern, Southern, Western
and Northern Ireland Ambulance Service

Advising ambulance control of DNACPR status at time of booking and insert NIAS booking reference number at the top of this page.
Advising ambulance control immediately if there is a change in the patient’s DNACPR status.