“Sharing and Involving”

A Clinical Policy For Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults (18+) in Wales

Revised Policy: Version 5
URL: www.wales.nhs.uk/DNACPR

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DNACPR Form (Adult) DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

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A Poem

1. Introduction and Objectives

Health professionals have a duty to make sure people who should have Cardiopulmonary Resuscitation (CPR) receive it, and those that should not, do not.

Cardiopulmonary resuscitation (CPR) can, in theory, be attempted on any person when their heart and their lungs cease to function. But CPR effectively starts at the point of death. The clinical outcome is largely dependent on the individual clinical factors that led to the situation. In many instances, the procedure does not work at all, or does not result in a good clinical outcome. In the rare circumstance when people with palliative illnesses do survive it, there is significant risk of harm and prolonged suffering from CPR - including long term severe brain damage, and the need, in some cases, for prolonged admission to ITU, and a possible further cardiac arrest or natural death, resulting from the underlying disease processes.

Inappropriate attempts at CPR can lead to unnecessary torment for patients and those important to them, which may involve the ambulance service and even the police, potentially causing further distress.

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

There has been increased focus on matters relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and forms in the media. This is possibly a reflection of the fact that the clinical and ethical issues are acknowledged to be of such an important and personal nature. Whilst we meticulously plan care with patients for interventions at the beginning of life, all too often we fail to have equally meaningful discussions relating to a patient's wishes at the end of life. Frequently it seems that there is too little discussion, too late. **Such discussions should be offered, but never forced on individuals. All decisions should be made based on individual situations, and must never be made in a discriminatory fashion. Clinicians have a duty to consult.** To this effect, this DNACPR policy takes account of the recommendations set out in the Older People's Commissioner for Wales 'Protection of Older People in Wales- A guide to the Law' document and the European Convention on Human Rights.

Workshop Comment:

"Care providers must become better at establishing an individual's views on cardiopulmonary resuscitation"

"This open policy hopes to start a public dialogue in relation to patients' wishes at the verv end of life".

An information leaflet for patients, relatives and others close to them is provided with the national policy.

1.1 Purpose and Scope of this Policy

This policy applies to all healthcare professionals in Wales who care for patients of 18 years of age and over in all care settings within the remit of NHS Wales. It specifically relates to cardiopulmonary resuscitation (traditionally referred to as "CPR"), synonymous with cardiorespiratory resuscitation, which is the attempted restoration of circulation and breathing in someone in whom both have stopped. It does not apply to other treatments and care, including procedures that are sometimes loosely referred to as 'resuscitation' such as emergency rehydration, blood transfusions, intra-venous antibiotics etc. Therefore, the abbreviation 'DNR' (Do Not Resuscitate), or 'DNAR', or 'NFR' (Not For Resuscitation) is **not** used in this policy and **should be avoided where possible.**

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

The purpose of this policy is to provide a framework for professionals and NHS/charitable bodies in Wales to facilitate a consistent approach to decisions about the provision of CPR. Healthcare professionals (HCPs) involved in DNACPR decisions should familiarise themselves with this policy. This policy is compatible with Welsh policies on organ donation and consent. While death is inevitable, achieving a dignified, sensitive and shared approach in the understanding of CPR and its likely success or failure, is vital for patients and those close to them/concerned with their welfare. DNACPR decisions should always involve experienced professionals, with knowledge of this policy and training in communication of serious illness conversations. DNACPR discussions can be challenging, and they should be conducted in a calm, professional and reflective manner, and sometimes several conversations may be required. The decision not to attempt CPR on a patient is a **major clinical decision.** The clinical course leading up to this point may be of short duration for some patients. For others it may follow a more gradual decline in health.

Workshop comments:

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

"The complications of CPR and also the concept of natural anticipated accepted death should be more openly discussed"

Establishing whether a patient is aware of the low success rates of CPR in certain circumstances, and the implications of this violent set of procedures, is a first step. Following on from this, rather than tasking patients and their loved ones with a decision on whether they would want CPR or not, it is more prudent to sensitively convey the view of the healthcare professional (and team). For instance, that a decision on future CPR attempts, and a form to write this decision down is now necessary. This may involve several conversations, outlined by the Royal College of Physicians 'Talking about Dying Report'. The consideration of future physical attempts (CPR) to maintain circulation and breathing in the event of a cardiac arrest is also a **serious personal consideration**. In most cases a DNACPR decision will be made after a careful, planned discussion in partnership with the patient and involve those closest to them and concerned with their welfare. Decisions relating to DNACPR must be accorded a high level of prominence to ensure that discussions are allocated sufficient time, and views are explored. Patients and those close to them should have ample opportunity to explore what CPR and DNACPR is, how successful or unsuccessful CPR might be in their individual circumstances, and be offered resources including the Sharing & Involving Information leaflet, and online resources such as the Talk CPR videos, available bilingually on http://talkcpr.wales and http://talkcpr.cymru
Bilingual video media pads for patients, carers and healthcare professionals exploring CPR and DNACPR, via the Talk CPR videos have also been made available to GP surgeries across Wales, and there is a dedicated YouTube channel with patient/carer resources:
https://www.youtube.com/channel/UCKeh4IBAu38PH8kb1g5-7Og

It is possible to identify those patients for whom a cardiopulmonary arrest and a natural anticipated and accepted death, will represent the end to their life in the near future. **A "clinical concept" of a Natural Anticipated and Accepted Death (NAAD)** is introduced in this policy in order to offer guidance to clinicians as to when to consider a discussion in those cases where CPR would represent an unsatisfactory, undignified and clinically inappropriate intervention – or possibly where the burden of CPR in clinical context clearly outweighs realistic benefit. This prompt (NAAD) has been reviewed in terms of its relevance to the latest version of the policy & is still considered highly relevant. An individual, patient-centred approach is vital. The patient's fully informed personal perspective on CPR is of great importance, viewed in the wider clinical context. It is also very important to identify those patients who would adamantly refuse future attempts at CPR, following informed discussion. To this effect, other Advance and Future Care Planning concepts such as Advance Decisions to Refuse Treatment (ADRTs) have been afforded greater prominence as part of the Sharing & Involving NHS Wales Executive website, and bilingual forms for patients and clinicians can be accessed there (NHS Wales Advance & Future Care Plan tab):
https://executive.nhs.wales/functions/networks-and-planning/peolc/professionals/advance-and-future-care-plans/
or short link: www.wales.nhs.uk/AFCP
This policy has been developed in partnership with key clinical and non-clinical stakeholders (including patient and carer representatives who sit on the national group) in order to develop a consistent

approach to DNACPR across the NHS in Wales and to ensure that the decisions reached are based on an individual patient's needs. It outlines an open, personal approach to DNACPR decision-making in Wales, an approach understood by clinicians, patients and their families - acknowledging the particular circumstances of every patient. The policy is available to the public and can be accessed by going to www.wales.nhs.uk/DNACPR . It is reviewed regularly to ensure it complies with current law and moral ethical codes, and guidance from professional regulatory organisations such as the Nursing and Midwifery Council and General Medical Council.

Objectives of this policy

The overriding principles of this policy are:

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

The primary objectives of this DNACPR policy are:

- To ensure that this important discussion is accorded the highest level of significance.
- To develop across NHS Wales a consistent approach to initiating, discussing, documenting and communicating decisions regarding CPR, ensuring every approach is individualised.
- To ensure an integrated approach to making DNACPR decisions.
- To ensure that an individual patient plan is in place across all relevant care settings **and that it can cross heath care boundaries including all health boards and trusts in Wales.**
- To ensure correct and effective communication to all those involved in the patient’s care.
- To ensure that decisions regarding CPR are made taking into account:
    - Whether CPR is likely to succeed.
    - The clinical needs of the patient.
    - The patient’s views.
    - Sound ethical principles.
    - All relevant legislation for example the Human Rights Act (1988) and the Mental Capacity Act (MCA) 2005 and the duties and obligations set by professional regulators.

- To make DNACPR decisions in a transparent way that is open to examination. This policy can and should be shared with patients and those close to them who wish to examine it further and can be accessed and downloaded from the following URL in English and in Welsh www.wales.nhs.uk/DNACPR
- To avoid inappropriate CPR attempts in all care settings.
- To ensure staff, patients, their trusted friends and family have appropriate information on making timely prior decisions relating to future CPR attempts and that they are able to discuss resuscitation issues when they wish to do so and that they understand the process.
- To clarify that patients and their loved-ones should not be asked to decide on CPR when it would be highly likely to fail - although they should be informed and have a say about the views/decisions of the clinical team, including that a DNACPR form is felt to be necessary
- To clarify that patients, contrary to occasional media reports on this issue, are never asked to sign DNACPR forms themselves. The form has only healthcare professional signatories. Other types of forms are available that patients sign themselves, specifying future treatment refusals incl CPR, such as the NHS Wales ADRT form www.wales.nhs.uk/afcp
- Once a decision has been reached, to offer each individual and/or their proxy a copy of their DNACPR form, to ensure it is with them and can be shown to visiting healthcare professionals in future.
- To ensure that clinical staff who are caring for people with communication difficulties or who may be vulnerable will provide a decision-making process that is clear and appropriate for their needs.

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

Clinical staff must understand the personal implications of a DNACPR decision. Achieving this requires clinical reflection, excellent communication and informed decision making. If personal discussion with the patient is not possible (including for reasons of mental capacity) the same principles must apply.
Such discussions will likely feel very significant to patients and those close to them, and may cause fear and anxiety. This will on occasion only manifest hours or days after the conversation has been held, so follow-up should be discussed when a DNACPR discussion has been held.

2. Definitions

Throughout this policy "DNACPR" refers solely to the provision of Cardiopulmonary resuscitation and not to any other aspect of the individual's care or treatment options.

2.1 Cardiac Arrest

This is the sudden cessation of a clinically detectable cardiac output. The heart has stopped pumping due to abnormal electrical rhythm activity and the patient has started to die. According to the UK Resuscitation Council Guidelines, heart rhythms associated with cardiac arrest are divided into two groups: shockable rhythms (ventricular fibrillation/pulseless ventricular tachycardia (VF/pVT)) and non-shockable rhythms (asystole and pulseless electrical activity (PEA)). The main difference in the treatment of these two groups is the need for attempted defibrillation (electric shocks to the bare chest) in patients with VF/pVT.
By contrast, 'agonal' heart rhythms occur in people undergoing a dying process and constitute a very slow heart rhythm that eventually ceases, and do not respond to attempts at CPR.

2.2 Cardiopulmonary Resuscitation (CPR)

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

2.3 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

This refers to a specific process of discussion and documentation NOT to initiate future CPR in the event of a future cardiac arrest and natural and anticipated dying event. It must be made clear to the patient, those close to the patient and also to the health care team that a DNACPR decision does not have repercussions on any other element of treatment and care. For example, many people who have a DNACPR form, will still receive ongoing chemotherapy or other treatments that may help reverse potentially reversible problems.

2.4 Joint Statement (see section 11)

The joint statement refers to the BMA, Resuscitation Council (UK), and RCN's report - "Decisions Relating to Cardiopulmonary Resuscitation". An update of earlier versions of this document represents an important addition to this area of clinical decision making. For the purpose of the latest version of our DNACPR policy, updated guidance from the Royal College of Nursing and Midwifery regarding nurses making decisions on DNACPR has also been taken into account.

2.5 Mental Capacity

The Mental Capacity Act (MCA) 2005 Section 1(2) recognises the basic principle that an adult must be presumed to have the capacity to make their own decisions, unless there is reason to doubt their decision-making ability and an assessment has then established that they lack capacity to make the

relevant decision – in this case the ability to engage in discussions about treatment escalation planning including DNACPR. In order to lack capacity to make this decision, the clinician must establish that a person is unable to understand, retain, use or weigh the relevant information and/or unable to communicate their wishes. make the DNACPR decision and/or communicate their wishes. A person must be assumed to possess the mental capacity to make a particular decision unless the reverse can be positively demonstrated for that *specific* decision. Identifying early on in the course of an illness the possibility that the patient may, at some time in the future, lose the capacity to decide for themselves will ensure that, wherever possible, a well-informed DNACPR decision can be reached or, where appropriate, achieved in the patient's best interests.
It should be borne in mind that for very ill patients, where a likely deterioration to death is envisaged in the near future, the ability to participate in discussions about treatment escalation planning and CPR can be impaired and compromised, and so clinicians should carefully assess and document. Clinicians should adhere to their local health board or trust guidance, policies and procedures, especially where there is a doubt about a person's capacity with regard to a specific decision. A pragmatic approach towards this can be found here: https://www.mentalcapacitylawandpolicy.org.uk/capacity-for-care-providers/ with a video presentation by barrister Alex Ruck-Keene KC, with regard to the law in England and Wales. Significant decisions made on behalf of a patient who lacks capacity must be recorded and provide evidence that they have been taken in line with the requirements of the Mental Capacity Act 2005 and associated Code of Practice.

2.6 Independent Mental Capacity Advocate (IMCA)

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

2.7 Advance Decision to Refuse Treatment (ADRT)

This refers to a decision by an individual to refuse a particular treatment in certain circumstances. A patient may have created an ADRT that includes a wish to refuse CPR, and if this is valid (its creation meets the standards set out in the MCA) and applicable (relevant to the current circumstances the patient is in) then it is legally binding, and their wish must be followed. A DNACPR form by contrast, does not have legally binding status, but should be seen as a clinical decision aid, where an emergency situation that potentially requires CPR arises. Note that neither the patient, nor anyone on their behalf can insist on treatment that the clinical staff do not feel is clinically indicated, *even* if such insistence is included in a written document. Refer to the Mental Capacity Act and the Code for further details and in the event of uncertainty with regard to the validity of the ADRT document, seek legal advice.

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

Both of the above may have legal powers to assist with the decision-making process where the patient lacks decisional capacity at the time when a decision needs to be made. Some attorneys possess legal authority over best interests decisions about CPR (the LPA document should be checked to ensure that it donates the power to make decisions about life-sustaining treatment), and in such a situation the clinicians should provide clinical information to assist the attorney's decision making. Deputies by contrast will not have legal authority to refuse life sustaining treatment. In the situation of an attorney not possessing such authority, and in all situations when a deputy is involved, the attorney or deputy should be involved in any best-interests discussions about future CPR. Care should be taken to check the validity of any held documentation and the scope of their powers, if time permits this to be done. Where such persons are considered not to be acting in the patient's best interests it is important to seek legal advice. The Office of the Public Guardian has detailed information on this.

2.9 Natural anticipated and accepted death (NAAD)

In less acute situations, a gradual decline in clinical well-being may be noted and ultimately death as a result of the current disease process may be envisaged. Accordingly, in the context of the patient's condition, death might be considered to be clinically inevitable in the days, weeks or months to follow. The team's reflection might be that death is the consequence of the disease process itself (natural) and is reasonably envisaged (anticipated) to occur in the near future. See also section 5.2 and 5.5.2.

3. Policy development and implementation

3.1 **Process of policy development**

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

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

The policy will be updated as deemed necessary and reviewed every two years in light of comments received, audit points raised and incidents that arise. Initially this process was led by the All-Wales DNACPR Policy Group (until 2019), but this process is now undertaken by the All Wales Advance & Future Care Planning Strategy Group (AFCP), under the auspices of the NHS Wales End of Life Care Implementation Board and the Deputy Chief Medical Officer for Wales. The All-Wales AFCP Group reviews if any major issues have emerged, or whether new legal guidance has been handed down by relevant courts, which may require policy adjustment. For instance, the Tracey [2014] and Winspear [2015] court judgments have been taken into consideration for this policy. The recommendation for routine audit of local DNACPR procedures against the recommendations of this policy, has been with Local Health Boards and Trusts since the inception of the All-Wales policy in 2015. Health boards and Trusts should all have one or more representatives who lead on this area. Recommendation of frequency of such audits is every two years, but this is for Health Boards and Trusts to decide. Learning and outcomes from audits must be shared with stakeholders and can be fed back regionally and/or nationally to the AFCP Strategy Group.

3.2 **Principles of policy implementation**

Health professionals across NHS Wales must be made aware of this policy and also of their responsibilities to patients and those closest to them in order to meet the standards required. Staff should be made aware of this clinical policy through training measures (see Section 10) employing Local Health Board/Trust mechanisms in accordance with the local management of policies and procedures. This requires Health Boards and Trusts to work closely in partnership with the other key organisations including the Welsh Ambulance Service Trust. Staff must operate this policy within NHS systems of information governance, with the clinical information relating to DNACPR being accessible to those teams providing clinical care for the patient. It is recognised that there may be exceptional clinical circumstances when a first responder has to make an immediate decision that favours the right to life with no time to evaluate DNACPR status, hence providing CPR as the clinical situation demands.

4. DNACPR in practice – key principles

4.1 When DNACPR status is unknown

Unless a valid DNACPR decision is in place, (with either a completed All Wales DNACPR form, or a valid Advance Decision to Refuse Treatment (ADRT) or another Advance & Future Care Plan form specifically relevant to CPR), all patients must be urgently assessed for the likelihood of CPR working for them, or not. If a significant possibility of a cardiac arrest or death was not previously envisaged, a presumption in favour of giving CPR is made, but must be guided by the emerging relevant information in each emergency arising. Circumstances can be highly variable and therefore require detailed individual assessment each time.

4.2 Circumstances when CPR would not restore circulation and breathing

If the clinician with responsibilities to the patient, ideally in liaison with the multi professional team, is as certain as they can be that future CPR attempts would not re-establish effective circulation and breathing in the patient, then CPR should not be offered or attempted. When this is the case, discussion with the patient should take place in the spirit of good practice and openness. For some patients there may be individual clinical circumstances where such discussion might lead to physical or psychological **harm**; in such circumstances the clinical reasons for avoiding discussion with the patient must be clearly documented, and the harm that may occur should be clearly outlined. A decision should also be reached on consulting those close to the patient, without breaching trust or confidentiality. The Tracey judgment of 2014 made clear that the potential for causing distress is not sufficient reason not to involve a patient: "*If […] the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her.*"

4.3 DNACPR Discussion – openness, with confidentiality, partnership & no discrimination

Workshop comment:

"Discussing DNACPR in the community setting means that a clear plan is understood by all"

All patients faced with this discussion require support from those providing care. Whenever possible, with patient consent, the person(s) they have chosen to be involved in discussions about their care and treatment should be invited to be present during the discussion. The clinician must be aware of the current clinical status and the benefits and risk of harm from CPR. A discussion can ensue, views can be obtained, and the clinician should aim to explain what CPR entails and why it is not recommended in certain circumstances and why its success is so low. The NHS Wales 'Talk CPR' videos on http://talkcpr.wales, explore ways of viewing CPR as part of a myriad of treatments on offer in hospitals, and recommend that such discussions need not only focus on the most extreme interventions: the patient may also have views on other treatments involving hospital admission. Such discussions can then reassure patients and those close to them, that opting out of CPR does **not** prevent them from receiving many other treatments in future, such as radiotherapy for cancer, or dialysis for renal failure. A shared understanding can then lead to a shared view that can be reached in partnership with full involvement. Patient confidentiality must be respected at all times. Where there is a difference of views between the clinical team and the patient and those close to them, it is best practice to get a second opinion, if the clinical team feel that a DNACPR form should be in place.

Importantly, while simultaneously reinforcing the fundamental professional requirement not to harm and acknowledging that future CPR cannot be demanded by patients or those close to them, the Court of Appeal in 2014 asserted a human rights presumption for ***involvement* in such DNACPR decisions**. This involvement in a decision is a very different responsibility from mere informing/communication of an already finalised one. Involvement requires an open mind and a desire to understand and achieve wherever possible the wishes and preferences of the individual concerned; and consideration of the person's views in the final decision, even if they are counter to the healthcare professionals' views.

It is acknowledged that for some patients, such conversations are straightforward, and they may already have formed their own views on what their future care, especially in the last days and weeks of life may look like. But for others, such conversations can be overwhelming, and therefore putting the patient in control of the conversation, offering to stop the dialogue at various points if it is getting too much, may be a better way to convey the important points around DNACPR. Should this be the case, then an offer to readdress the subject at later time-points can be made.

All adults should be considered as being eligible to be involved in such discussions if they are foreseeably approaching the end of life, and this will of course include people for instance who have co-existent learning disabilities. It is unacceptable to exclude anyone in a discriminatory fashion, and everything should be done to ensure full involvement. It is also unacceptable to use a learning disability alone as a reason to hold a DNACPR discussion, as outlined later in this policy. **Anyone holding DNACPR discussions should make clear this it is for the medical conditions that are likely to cause a naturally anticipated and accepted death in the near future, not any pre-existing mental health conditions or learning disabilities.** Clinicians involved in such discussions must individualise each situation and ensure as much information sharing can happen, to allow the person to understand and be part of the discussion.

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

4.4 DNACPR Discussion – communication with those close to the patient

> ***"Staff should bear in mind that those most close to the patient may not always be immediate family members" (Transgender Wales)***

Whenever clinically possible, all patients should be offered the opportunity of support from a close individual for the DNACPR discussion. A decision from a patient to decline such an offer of support must be respected and recorded. Individuals close to the patient will naturally be anxious about them and whenever possible should be kept informed of the clinical progress of the patient. Whilst such discussion between the patient and those closest to them are to be encouraged, if a private DNACPR discussion is requested by the patient, it is sensible at its conclusion to confirm with the patient whether they wish the conversation to remain in confidence. You must respect the position and record that decision in the clinical record. It should be kept in mind that a patient who agrees to take their DNACPR form with them to their own home, should consider that sharing this information with those close to them will likely be necessary; in order for the existence of the form to be adequately communicated to any arriving clinical staff, such as paramedics, someone from the household will need to be aware of its existence and where it is kept.

When discussing DNACPR with a patient, it is important to bear in mind that some may find it easier if a person close to them is present, and clinicians should offer this. Health Boards and Trusts should remind clinicians that patients should be able to be supported by their family/friends/close-ones during such potentially challenging conversations. Asking consent of a patient to do so, may involve a broad opening statement to clarify, such as "There is a conversation I would like to have with you and those close to you, together, about how we address treatments later on, if you get more unwell? Some people don't find this easy and quite like to have a close friend/family member with them. Would someone be able to come in and join us, so we can have this conversation together?"

Patients lacking sufficient mental capacity with regards to the specific decision

If a clinician has reason to doubt a patient's capacity to engage in discussions about treatment escalation planning including DNACPR, then they must assess capacity for this specific decision before treating the person as unable to make their own decisions. Patients have a right to support to make decisions before being treated as unable to do so, and clinicians must understand what might optimise their decision making- for example the support of familiar people, provision of accessible information and adapting to their communication needs.

Before making and recording a DNACPR decision for a patient who lacks capacity to give their views about treatment escalation planning including CPR and DNACPR, it is important to consult as widely as possible. Those close to the patient, who can help inform a best interests decision, should be consulted, so long as it is practicable to do so, unless the clinician can see any reason why this would not be appropriate. *Best interests decisions* should explore with those who know the individual, to communicate with the healthcare team what the likely patient's views on this particular intervention would have been. If the decision is urgent it is usually possible to consult them even if it is inconvenient, and attempts to contact significant others, even if unsuccessful, should be clearly documented in the notes with date, time and numbers contacted.

If a DNACPR decision is not urgent, consider deferring it until relevant people close to the patient are available. If the decision is to be 'made on a balance of benefits and risks', those close to the patient may have information about 'previously expressed wishes and about what (outcomes) the patient would have been likely to consider acceptable'. Such information will inform a decision one way or the other. If the decision is to be made because 'CPR would not be successful', discussion with those close to the patient will involve information and explanation about CPR and about a DNACPR decision [refer to the guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing June 2016]. Further information, videos and guidance for patients, carers and healthcare professionals is available at:

http://talkcpr.wales/ (English language)
and
http://talkcpr.cymru (Welsh language)

And in the patient information leaflet via:
https://executive.nhs.wales/functions/networks-and-planning/peolc/professionals/dnacpr/patient-and-carer-information/

4.5 Documentation of the DNACPR discussion:

The standard All-Wales documentation for adult DNACPR decisions must be used in healthcare settings in Wales, in order to reduce risk and to aid clear communication about the decision. Supporting documents such as clinical correspondence letters, or Advance Statements, Advance & Future Care Plans (e.g. '*My Life, My Wishes*' Document in Wales, or '*Record of Advance Care Plans and Preferences* ACP-A' on www.wales.nhs.uk/afcp), or letters from other clinicians about discussions held, can be appended to the relevant form, for further reference. An ADRT form, where such a form refuses life-prolonging or life-saving treatment including attempted CPR, should, due to its legally binding nature, have *major* prominence over even a DNACPR form, but both can be used in conjunction if this is felt to help communication.

If a patient from England, Scotland or Northern Ireland arrives in Wales with a different form, this should be verified, scrutinised and informs clinical decision making in an emergency. Such correspondence can be cross-checked with healthcare professionals who have written the original form where there is sufficient time to do so. Where such patients with forms from other countries and settings are currently stable, a contemporaneous All Wales DNACPR form can be written, which cross-references and appends the original (external) document or clear photocopy thereof. See also section 8.5 "When clinical care extends between health sectors or across borders".

4.6 Wider communication of DNACPR decisions:

Immediate and effective communication of a DNACPR decision must take place so that all those involved with current and future care are made aware. It is the responsibility of the senior responsible clinician when discussing and/or countersigning the DNACPR form, to ensure appropriate communication has occurred. A form or clear/legible copy must be prominently placed in the patient's current medical record. For all settings this may include raising awareness outside the immediate place of care (see section 6.4). Electronic patient records should also prominently alert users that such a decision has been made and is in place. It is good practice to inform a patient that the DNACPR decision and form will be shared with others involved in their care, and to suggest that they or those close to them also alert other healthcare professionals they meet. Section 8 of the form should be filled in.

5. Making a DNACPR Decision

5.1 When should a DNACPR discussion be contemplated?

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

Determining whether someone may be at risk of dying, or is sick enough to die, can be challenging, but indicators like the Gold Standards Framework with its surprise question, and SPICT (Supportive and Palliative Care Indicator Tool) have been evaluated successfully.

Discussions should ideally be conducted by a team-member who has frequent interaction with the patient and who is familiar with the All-Wales DNACPR policy. Section 9 of this policy also contains further areas of learning, including ESR modules that HCPs may wish to complete if they are involved in such conversations.

If neither a DNACPR decision nor a specific Advance Decision on CPR exists, and the views of the patient are not known, the presumption is that CPR will be considered. This applies unless at the time of an arrest the clinician is as certain as they can be, that they possess sufficient information about the patient to judge that CPR cannot be successful.

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

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

Clinical presentations can be highly variable. In some cases, the level of physiological compromise at presentation indicates a likely imminent decline to a cardiopulmonary arrest. For others a more gradual deterioration may be the anticipated course. Sometimes a decline in health may be first suspected by carers and those closest to the patient and occasionally by the patient themselves. These represent common general clinical scenarios when a DNACPR position might initially be considered. See also section 5.5.2 on NAAD.

Audit point 3 – Team discussion relating to DNACPR

The possibility of a person dying soon should lead to a team discussion relating to DNACPR – with an additional community perspective whenever possible. The clinical decision framework (section 5.2) may be a helpful guide. The decision to move to a DNACPR discussion should be recorded. The DNACPR discussion itself should take place as soon as possible thereafter (within 12 hours).

5.1.1 If CPR will not restart the patient's heart and maintain breathing

If the clinical team is **as clinically certain as possible** that attempting CPR would not re-establish effective circulation and maintain breathing, then CPR need not be attempted. For instance, in a patient where the dying phase has been reached, CPR is not going to restore a normal heartbeat or breathing when these have ceased. The electric currents given to the bare chest during CPR, cannot restore a so-called agonal heart rhythm of dying, back to a 'normal' rhythm. The 2 rhythms that sometimes respond to electric shocks given during CPR, are ventricular fibrillation and pulseless ventricular tachycardia, and these usually present with a sudden collapse of a patient, whose heart has suddenly ceased functioning, before all other organs. This is in contrast to the patient who has a slower decline in the dying phase and whose heart is effectively the last organ to cease functioning and shut down. At such a point, no manner of CPR will restore life and may be seen as an undignified intrusion.
A patient cannot demand a treatment that is not clinically indicated. To provide CPR in such circumstances as described above would be futile. The decision is a clinical one centred on the clinical picture at the time. The position should be communicated to the patient (see section 4.3) and, with consent, to those close to them. *However, if a patient has clearly indicated that they would like future CPR attempts to be considered, contrary to the clinical team's recommendation, then Section 8.3 of this policy should be consulted.*

5.1.2 If the potential "adverse effects" of CPR outweigh any potential benefits

Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient. The individual may only survive for minutes or hours. The patient's recently expressed wishes and decisions are important to ascertain. Teams in consultation with their patients/those close to them in this case, should consider whether a natural and anticipated death free from the invasive interventions involved in the process of CPR, may be preferable. Such a view that a Natural Anticipated and Accepted Death is likely in the coming weeks or months, may trigger a discussion about ceilings of treatment, including whether CPR should form part of future considerations, or not.

Audit point 4 – Consider the possibility of "NAAD / DNACPR"

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

5.1.3 When an Advance Decision to Refuse Treatment (ADRT) which includes refusal of future CPR is in place

Patients should be asked at an early stage of contact if they have made an ADRT in relation to CPR. These documents are legally binding and are sometimes referred to as Advance Decisions, Advance Decisions to Refuse Treatment, ADRTs. There is an expectation that patients and/or their families will endeavour to ensure that healthcare teams are made aware of the existence and content of any specific Advance Decisions.

If there are reasons why the attending clinicians believe an Advance Decision to be invalid or inapplicable this must be carefully documented within the patient's record and discussed urgently with the legal representative for the health board, and/or Patient Safeguarding Representative. It may thereafter need to be urgently discussed with the Court of Protection. When a patient is known to have a valid and applicable ADRT, at an appropriate time a DNACPR form should be completed. Where the existence of an Advance Decision is unknown with no time to investigate – the presumption is for attempting CPR, weighing up all contemporaneous information and if this is considered to have a realistic chance of benefit. All Wales ADRT resources and bilingual forms are available via the Sharing and Involving website: www.wales.nhs.uk/AFCP

Audit point 5 – CPR-specific 'Advance Decisions to Refuse Treatment' (ADRTs) – identification at point of contact

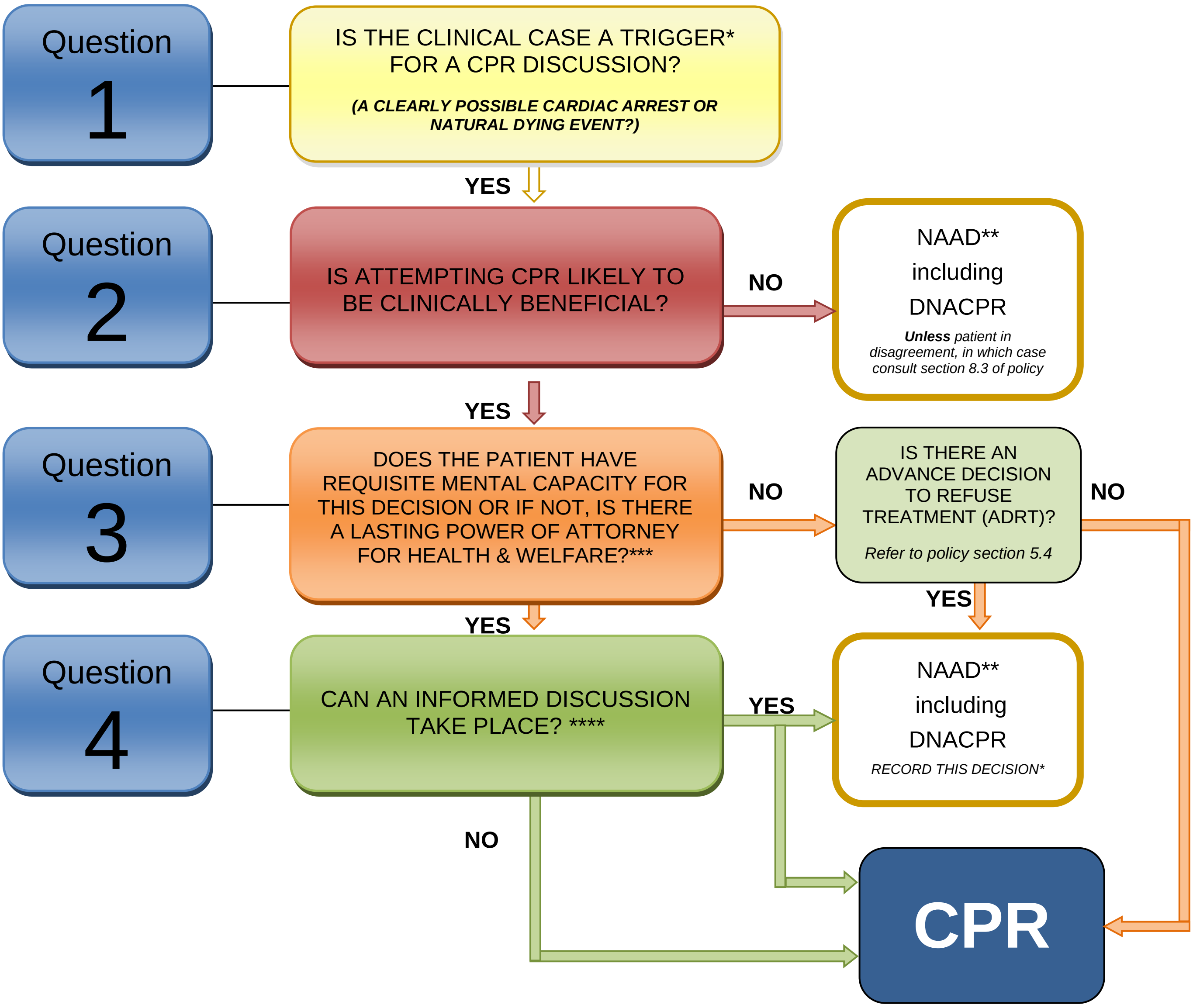
It is important to ascertain the existence of a specific ADRT for CPR at an early stage. This will ensure continuity of knowledge throughout the patient's journey and prevent inappropriate arrest calls.

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

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

5.2 Framework for a CPR/ DNACPR Decision

SCHEMATIC FRAMEWORK FOR DNACPR DECISION-MAKING



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

***TRIGGER – may represent a traditional ‘clinical trigger’ where the clinician envisages a possible cardiac arrest or natural dying process as an anticipated consequence of the condition – or when the harm or risks of CPR clearly exceed the benefit (see e.g. GSF or SPICT section 5.1)**

****NAAD - See Policy Section 5.5.2.**

*****See Mental Capacity Act (2005) guidance paragraph 7.30– Health and Welfare Attorney must be designated to cover life-sustaining treatment decisions and be registered with the Office of the Public Guardian. If no ADRT is in place or ADRT not considered valid or applicable, consider Section 5.4 relating to Mental Capacity Act.**

******Note that the patient may change his/her mind at any time. Also, for interventions with significant risk of cardiac arrest, a CPR discussion must occur when obtaining informed consent for the procedure.**

5.3 How a DNACPR discussion should be conducted

Workshop comment:

"Approaching DNACPR sensitively can help alleviate a patient's anxiety and even provide those close to them with more clarity"

The patient *is* **the priority** and must be at the centre of the discussion. For this reason, the initial approach made concerning DNACPR, must be with great tact, with sensitivity, and always with forethought to any communication and language needs. DNACPR discussions must be based on a spirit of candour, openness and trust, armed with clear clinical knowledge of the patient. The approach to the discussion should always bear in mind the emotional needs of the patient and those most close to them. **A DNACPR discussion should never be rushed and should be approached with recognition of the individual's particular circumstances, values and beliefs. It should never be forced on anyone who does not wish to talk about this topic that may cause them psychological harm. Consider not solely discussing CPR/DNACPR but include other potential future interventions/decisions that may come up. The www.TalkCPR.wales resources encourage a treatment ladder approach: clinicians may wish to discuss views on a whole host of future options, at different lower or higher rungs of a treatment ladder. For instance, "Would you, in future, be happy to consider admissions to hospital for intravenous antibiotics and fluids if you developed a severe chest infection and became very drowsy?". Discussing different treatments and then moving up the rungs of a metaphorical treatment ladder (with the intensity of treatments increasing the higher the ladder gets) will make a patient/relative aware of how many treatments are still available, even if the treatment at the top of the ladder, CPR, is not likely going to work or be offered. A treatment escalation type discussion for future events can therefore also be quite reassuring for a patient, who has been told that CPR will not work.**

Discussions should therefore ideally take place in the context of taking informed views on other clinical interventions, for instance, a patient may wish to express that they still wish to have clinicians consider intravenous antibiotics, urgent blood transfusions, immunotherapy, surgery, to reverse certain potentially reversible problems, but wish to opt out of any future CPR attempts. The 'treatment ladder' concept can be found in this video: "Top Tips for Sensitive DNACPR discussions" http://talkcpr.wales/talk-cpr-videos/

Discussion should also never be centred merely on 'filling in a form' but focus far more on the essence and the value of such conversations, and the potential benefits and what matters most to patients and those close to them. Benefits of advance & future care planning discussions derive more from their process, than from any plans they produce, and recognising this is essential for provision of optimum care for patients and their families.

Such benefits, that patients and those close to them can experience from advance and future care planning and DNACPR discussions, have been identified in several research studies. They include strengthened relationships with each other and their clinical teams, and support through the experiences of living and dying with worsening illness and bereavement. These benefits come largely from the conversations that constitute the planning process, particularly when these occur over time and include the patient's family and loved ones. Research evidence during the Covid pandemic concluded that families/those close to patient who had received information about ceilings of treatment and end of life care planning, had less risk of pathological grief after their loved one had died.

When recording discussions, date and method of contact (i.e., phone, in person) of conversations with the patient/ suitable representative must be recorded. This should apply to both successful and unsuccessful efforts to hold a discussion.

Audit point 6 – Named individual(s) for "close support"

Those closest to the patient (not always immediate family members) can provide valuable personal insight. It is essential for all patients to be asked early on to provide the name(s) of those they wish staff to communicate with, in the event of significant change in their condition and for this to be recorded. Establishing whether they are content to be contacted at all hours, is also important. Some use the term 'chosen family' to include non-marital partners or close friends.

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

Clinicians must allow adequate time for End of Life Care and DNACPR discussions. They should have received training to conduct these conversations and feel adequately prepared to do so. They should possess knowledge of the patient's history and the clinical evidence-base/rationale for the discussion. The conversation should be as private as circumstances allow. The conclusion should be understood by the patient. A nominated team-member should offer further contact with the patient to enquire if clarification is necessary.

5.4 DNACPR and mental capacity

"It is vital to make every effort to hear the voice of those with reduced capacity" (Mencap Wales)

The Mental Capacity Act (2005), which applies to Wales and England, defines the rights of patients and describes the responsibilities of those who provide care. It reinforces the understanding that people who lack the capacity to make their own decision about the specific issue at hand at that particular time, must remain at the centre of decisions that affects their lives. It contains best interests provisions which should be followed if decisions are made when a patient lacks mental capacity, and at the core of best-interests determinations is the individuality of the patient.

Impaired function of the mind or brain is common in many medical conditions and care must be taken to ensure that those who assess decision making capacity have the appropriate level of skill. Mental capacity can also fluctuate, and therefore a highly individualised approach for each patient and those close to them is required, sometimes with *multiple* attempts to explore views.

Cases where capacity may be impaired, demand a flexible, thoughtful approach from the clinician. The first step in the process must be to perform an assessment on whether a person has the mental capacity to participate in discussions about CPR and treatment escalation planning.. Whilst this can be performed by any clinician with the appropriate skill, in more complex cases, help from speech and language therapists, social workers and liaison psychiatry can sometimes be very helpful. Where the patient is assessed to lacking capacity with regard to a specific decision, this should be carefully recorded, i.e. the evidence that on the balance of probabilities, the individual lacks capacity to…make decisions about TEP including DNACPR, for instance, should be determined in written notes. This need not always be on a specific form provided by a health board or trust but can be captured in the clinical notes and records.

Workshop Comment:

"For DNACPR – staff must be aware of, and address, any communication needs the patient might have".

The extent to which support must be provided before concluding that a patient lacks decisional capacity is dictated by the urgency of the decision, and whether steps are practical and appropriate, but clinicians must be mindful that there is a high bar for justifying why support was not given particularly in situations where the decision was not required urgently.

It is also important to consider that sometimes patients experience a temporary loss of decisional capacity. If there is an expectation that the person's ability to make decisions may improve in the near future, such as after recovery from acute illness, then consideration must be given as to whether the capacity assessment can be delayed until such time that they are more able to make decisions. If it cannot be delayed but the person's ability to make decisions does then improve, whether expectedly or unexpectedly, the capacity assessment should be repeated to account for this change in their ability.

The current views of the patient should still, if possible, be taken into account as well as the views expressed before capacity was lost. Decision makers should also consult those closest to the patient. Where this is not possible and where there is no appointed Lasting Power of Attorney (LPA) for Health and Welfare, an independent mental capacity advocate (IMCA) or equivalent deputy should be appointed. This will help ensure that personally appropriate decisions for the present and the future are made and ensure independent safeguarding of the process (refer to the Mental Capacity Act and its Code of Practice for more detail).

A DNACPR decision must never be implemented purely on the basis that the patient lacks capacity. All NHS staff must take responsibility for applying the same standard in relation to DNACPR to all patients. If a patient lacks capacity and a decision is made in his or her best interests in accordance with the MCA then the rationale and justification for the best interests decision should be clearly recorded in the notes, for instance by way of a best interests balance sheet, if at all possible. A 'Future Care Planning' form plus guidance document is available from the NHS Executive AFCP site www.wales.nhs.uk/afcp (Future Care Plan Form - Record of Best Interests Decisions RBID for People who Lack Mental Capacity). This document when through a multidisciplinary legal review conducted by a UK law firm with expertise in mental capacity law, Gregg Latchams/Shakespeare Martineau in 2021.

All information available about a person's wishes and preferences (including evidence of past records) should be taken into consideration, including documented prior discussions, advance statements of wishes and preferences, and prior records of best interests decisions. For individuals with fluctuant, intermittent mental capacity, ascertaining their views and preferences whilst they are deemed to *have* mental capacity, can be important to inform later points where they lack capacity and decisions are required.

Such decisions should always be understood alongside the *Winspear v City Hospitals Sunderland NHS Foundation Trust* judgment: if a person lacks decision-specific mental capacity at the time, the resulting best interests decision requires involvement, where practical and appropriate, with appropriate family / proxy/ welfare attorney(s) irrespective of the time of day or night. Attempts to contact them, even if unsuccessful, should be clearly documented.

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

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

Audit point 9: Mental capacity and mental health

Clinical staff should also be aware of the effect that concurrent mental health conditions might impact on a patient's capacity. If it is felt that a significant mental health co-morbidity exists, psychological or psychiatric assessment (depending on need) prior to DNACPR discussion should be considered. This can also ascertain whether future conversations about this topic may cause harm to the individual.

5.5 Deciding that a case warrants a DNACPR decision

The DNACPR discussion framework is illustrated in section 5.2. This includes clinical events that might act as a "trigger" for a team based DNACPR discussion. It also outlines questions clinicians should ask themselves in order to decide whether a clinical situation is one which might lead to a broader discussion with regard to end of life care (which as part of it may include DNACPR) with the patient.

5.5.1 DNACPR Decision

In some cases, it will be clear that the clinical position is irreversible, and that a *natural anticipated and accepted death* (section 5.5.2) is inevitable. Such circumstances for example could occur in the urgent acute setting or following the rapid irreversible decline of a known previously stable condition in the community. The conclusion of the clinical team might be that it would not be in the interest of the patient to attempt CPR, because it would not work; a DNACPR decision can then be made. Unless there is very good reason to the contrary, the clinical basis should be discussed with the patient as well as their nominated individual to be involved, and a DNACPR decision with clinical reasoning clearly documented. Where there is disagreement between patient/proxy and the clinical team, section 8.3 of this policy should be followed. As outlined in section 4.2, such conversations should be offered to the patient, but where a patient declines them, this should be respected. Asking frequent 'checking' questions like "*Do you wish me to stop this conversation at this point and not continue?*", or "Is this all a bit much, shall I stop?", may be helpful so that a patient feels in control of the pace and content of discussions, and to avoid lasting harm. Most of the patient/carer groups we talked to favoured a frank approach with as much detail as possible, even if it risked being distressing.

Importantly, while simultaneously reinforcing the fundamental professional requirement not to harm, and that cardiopulmonary resuscitation (CPR) cannot be *demanded* whatever the patient's wishes may be, the UK Court of Appeal has asserted a human rights presumption for *involvement* in such DNACPR decisions. This *involvement* in a decision is a very different responsibility from the mere *communication* of a finalised one, requiring an open mind; the desire to understand the views, and achieve wherever possible the wishes and preferences of the individual concerned; and consideration of the person's opinion in the final decision – which then needs to be communicated appropriately.

5.5.2 NAAD (Natural, Anticipated and Accepted Death)

Where a significant decline in clinical well-being has been noted, caused by current disease processes especially in those with multiple long-term conditions, subsequent death is highly likely, although predicting timescales can be challenging. The term 'sick enough to die' has been used in such situations (*Mannix K, "With the End in Mind" 2018*). Accordingly, in the context of the patient's condition, death might be considered to be clinically inevitable in the days, weeks or months to follow. This may be the case despite the maximum efforts of the clinical teams involved. The patient may or may not be receiving some care from palliative care specialists. The team's reflection might be that death is the consequence of the disease process itself (natural) and is reasonably envisaged (anticipated) to occur in the near future, usually in the next 6-12 months, or less. This does not mean that a DNACPR form that is older than 6-12 months is not valid, it merely reflects that predictions can be challenging. It does not change the fact that attempting full CPR, at the moment of death, is not going to work and will likely cause great distress. Many patients chose to hold their DNACPR form at home, or on their person in the last ***few years*** of their lives. **A form that is several years old does not lose its validity, but it may as a prompt to rediscuss with the patient and those close to them whether end of life care preferences remain the same.**

Workshop Comment:

"NAAD represents a tripartite system – recognising the natural course, one that is clinically envisaged and where there is an agreed, shared position"

A discussion should take place, and (if there is consent to do so), may include the person(s) they have chosen to be involved in their care and treatment. A joint position that a Natural, Anticipated and Accepted Death (NAAD) may be likely in the near future, can be the agreed shared position. NAAD is not a conclusion in itself. It would however represent a clinical position from which a DNACPR position follows. It is NOT a decision for the alteration of any other aspect of care and it should lead to further discussions as to how appropriate care can be achieved. **If a NAAD is anticipated and constitutes a likely possibility in the coming days, weeks or months, it is vital that it is conveyed to the patient and those closest to them that this would usually lead to a DNACPR discussion, together**

with a clear explanation that all clinically appropriate care will be provided. For more information on NAAD, see: Taubert, M., Rose, B. and Rigby, M., 2023. Do not attempt cardiopulmonary resuscitation decisions (DNACPR)–Policy approaches in Wales. *Clinics in Integrated Care Journal*, vol *19*, p.100149.

Many DNACPR decisions take place against a clinical context of chronic illness with gradual deterioration and multiple co-existing illnesses. In these circumstances, a planned fully informed discussion can take place. In all care settings the discussion must cover the risks and the burdens as well as the likely outcome from CPR. A shared understanding of what matters most to the patient, those individuals close to them, is essential for all clinicians involved. In conclusion, a position that a Natural Anticipated and Accepted Death might be likely in the near future can act as a trigger for patients, carers, doctors, nurses and allied care professionals to elicit views on future treatments and then lead to a DNACPR decision. **The presence of a DNACPR form on a person's records, does not prevent other treatments such as kidney dialysis, chemotherapy, immunotherapy, surgery or other interventions to go ahead, it merely clarifies the decision on CPR itself.** Indicators to help HCPs with recognition of people who may be of risk of dying in the near future are mentioned in section 5.1 (Making a DNACPR decision) and in section 9 (Training).

5.5.3 DNACPR – for a patient with an ADRT (sometimes known as 'Advance Decision')

A patient aged 18 or over, may have a specific Advance Decision to Refuse Treatment (ADRT) in place with a previously expressed decision withholding permission to attempt CPR, in the event of cardiac arrest or natural dying (see 5.2.3). Where known, this information must be shared with the clinical teams caring for the patient. An existing ADRT will come into force only when a person loses mental capacity to engage in and participate in the required decision. Otherwise, they (patient) must be asked and consulted, and may even state the opposite to what their ADRT had laid out, which should prompt the clinician to ask the patient if the ADRT is now being retracted, or whether the clinician has misunderstood what the patient has said.
A copy of the Advance Decision should be added to a completed DNACPR form. Where the patient lacks mental capacity to engage in and participate in the required decision, and where no specific Advance Decision exists, the default position is to consider giving CPR in the context of each emergency situation as it arises and weighing up all available information including other forms of documentation and/or what close family members/carers state.

An NHS Wales ADRT form is available on the AFCP NHS Wales Executive website, together with guidance notes for patients, carers and health and social care professionals: www.wales.nhs.uk/AFCP or https://executive.nhs.wales/functions/networks-and-planning/peolc/professionals/advance-and-future-care-plans/

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

Teams must respect the knowledge and concerns expressed by those close to the patient. Before discussing DNACPR, patients should be asked if they want the support of a named person. If the patient declines this should be clearly recorded and a desire for confidentiality must be fully respected. Clinicians should emphasize with the patient the importance and benefits of sharing such important information with their family or those close to them

5.6 Who should have the DNACPR discussion with the patient?

A registered healthcare professional (registered with GMC, NMC or HCPC), with good understanding of the person's current condition can lead such a discussion. Whilst frequently these discussions are brought up by clinicians, the opposite situation can also occur; the discussion may sometimes be brought up by a patient themselves in a clinical context. This can lead to explanations, reassurance and clarifications on any views or concepts surrounding CPR and DNACPR. Such discussions are not always held with a senior responsible clinician (see section 5.7) present, but it is good practice if they are, in particular if the patient knows them well. Some patients may prefer to discuss this or seek further clarification from junior doctors that they see on the ward every day, or a senior District Nurse, that has come to their house often, and where a trusting relationship is in place. There may also be occasions when a paramedic attending someone’s home may have significant conversations with a patient and family, and in Wales, paramedics have received Serious Illness Conversation Training in end of life care. In such situations, it is recognised that it would be artificial, were such a healthcare professional to decline to continue such a conversation, purely because they consider it only appropriate for a consultant or GP to lead on this, or feel that they are unable to sign a form. **If a healthcare professional is deemed competent and qualified enough to have an in-depth discussion with patients about CPR, then they must also be seen as competent and qualified to make and record a DNACPR decision, in essence as a record and product of the conversation they have just had.** See also section 9 - Training on DNACPR and community awareness.

Clinicians who hold such conversations with patients can include doctors, nurses and allied healthcare professionals, including physiotherapists, occupational therapists and paramedics who have contact with patients with palliative care needs, frailty and end of life care. They should have read the DNACPR policy and have line-managerial support to record such decisions. Each health board and trust will have quality assurance and governance procedures in place.

Conversely, it is important to note that not all doctors, nurses and allied healthcare practitioners will hold end of life care and DNACPR discussions routinely, nor record such decisions, so it will depend on the settings they work in. The fact that some occupational therapists who work in palliative care can hold very proficient end of life care planning discussions and talk about DNACPR with patients and those close to them, does not then lead to a conclusion that all OT’s have to hold these discussions, in the same way that this also applies to doctors and nurses.

The professional undertaking the discussion should record all the discussions in contemporaneous notes and also on the All-Wales DNACPR form. If there is insufficient space on the form, an additional sheet can be appended, and the clinician can state on the form “See further information in …[location]”. These discussions and decisions arising from them, should be relayed to all clinicians involved in this person’s care. They should inform the patient and/or the patient’s loved ones, once a DNACPR form has been completed. They should sensitively offer them a form to keep at home, acknowledging that this can be a distressing concept to contemplate, and that those close to the patient may find this distressing. The clinician should ensure that this is countersigned by the senior clinician with overall responsibility, unless of course that clinician has made and recorded the decision. The senior responsible clinician for this decision is the same as for any other medical treatments in that person’s care. They can sign either section 5 or section 6 of the form, both count as Senior Responsible Clinician (SRC) signatures. This policy does not define specifically who the SRC is, but traditionally has been the person’s GP or Consultant, and it may also be a non-medical clinician in some settings, such as a consultant nurse, consultant physiotherapist or consultant occupational therapist with oversight over a hospital setting, and with expertise in frailty, palliative care and end of life care discussions.

This should happen at the earliest possible opportunity, but the signed form already records a DNACPR decision and should be regarded as such in the event of a cardiopulmonary arrest.

Feedback from workshops and a national Future Care Planning conference held in Wales has stated that DNACPR forms with two signatures (one in section 5 and another in section 6 of the form), especially when these are multi-professional, engender a greater level of confidence in readers who review a patient at a later time point in an emergency situation. Therefore, seeking a senior responsible clinician signature on a DNACPR form should be seen as best practice.

Healthcare practitioners can also write into notes and onto the form where such a senior responsible clinician has been notified and has been in agreement with the DNACPR decision but has done so remotely. Such an entry should be signed and dated by the person who has contacted the SRC remotely, and they should add the SRC’s details and GMC/NMC/HCPC number into box 6, without the signature. Instead of filling in the signature, the clinician who is present can write “Discussed over telephone with [full name of SRC] on [date]. This will help provide context and reassurance to other professionals who read it.

The Advance & Future Care Planning Group have published a competency framework and accompanying guidance notes, for nurses and allied healthcare professionals who hold discussions and record them, and this is available on the www.wales.nhs.uk/DNACPR site as "*All Wales Competency Framework For Completion of the All Wales DNACPR Form (Section 5) by Registered Health Care Professionals*". This can be helpful as a resource to point to training modules but can also aid line managers to see the competencies that nurses and AHPs who hold such discussions regularly should be achieving, to be discussed at annual appraisals, for instance.

As of 2024, the British Medical Association has set out a Scope of Practice for the emerging role of Medical Physician Associates, Surgical Care Practitioners and Anaesthesia Associates, which clarifies that they cannot write and sign DNACPR forms or hold equivalent conversations (see References for link to document).

Audit point 11 – The All-Wales DNACPR form

For DNACPR to be recognised in Wales (outside of a valid and applicable ADRT) the All-Wales DNACPR form (see Section 6) must be completed. It forms the record of the DNACPR discussion. The clinician completing the form (when not a senior responsible clinician) must sign the form (Section 5 of form) and ensure discussion, agreement and countersignature by a senior responsible clinician as soon as possible . This should happen at the earliest possible opportunity, but the form already records a DNACPR decision, if it complies with all other aspects of the All-Wales policy.
Clinicians' registration number, as shown on the certificate of registration with their governing body (GMC, NMC or HCPC number) must be recorded in the relevant sections.
Aim for two professional signatures: whilst not mandatory, two clinicians' signatures on a form, one in box 5 and one in box 6, will increase confidence. Feedback from workshops and a national future care planning conference held in Wales has highlighted that DNACPR forms with two signatures, especially when these are multi professional, engender a greater level of confidence in readers who review a patient at a later time point, so seeking a senior responsible clinician signature on a DNACPR form should be seen as best practice. If the SRC has been informed and is in agreement, but unable to attend in person, the attending clinician can enter their details into box 6 on their behalf, including registration number, and indicate on form that the SRC was contacted remotely, and date and time this conversation.

In 2014 a judgment (Tracey v Addenbrookes) by the UK Court of Appeal stated:

"*The problems generated by decisions whether or not to impose DNACPR notices are inherently fraught. The question whether to consult and notify the patient is inevitably one of the utmost sensitivity and difficulty. Whether it is appropriate to consult will depend on a difficult judgment to be made by the clinicians. The decision will be difficult and sometimes controversial...***"**

5.7 Requirements of the Senior Responsible Clinician

A senior responsible clinician with oversight, in relation to this policy, must be available for all settings and will usually be a consultant or GP, although some healthcare settings are now also led and overseen by consultant nurses and consultant allied healthcare practitioners. This policy does not define who the senior responsible clinician in each different healthcare setting is, instead local structures should inform this. It is accepted that in some settings, associate specialist doctors, rather than consultants, may carry a deputising senior responsible clinician role for medical treatments and interventions. In some settings, senior nurses have overall responsibility for patients, including nurse consultants or advance nurse practitioners. The All-Wales DNACPR form allows for holders of NMC and HCPC numbers to sign box 6 of the form.

Signatories who are not consultants/GPs but who are senior responsible clinicians should seek written confirmation from their Health Board or Trust regarding whether they can appropriately fulfil oversight duties regarding DNACPR decisions. Line managers should contact the responsible manager or lead on DNACPR,AFCP, resuscitation, or mortality reviews at their Local Health Board or Trust, in order to gain clarification. Local Health Boards and Trusts may wish to designate standards of education and clinical involvement for any signatories, and we have provided further guidance and resources in sections 9 and 10 of this policy. Since 2023, we have also published an All-Wales competency framework, albeit for clinicians signing section, 5, however, this may also act as a standard for senior responsible clinicians signing section 6. A role in relation to DNACPR decisions should also be discussed at annual appraisals and reviews.

Senior Responsible Clinicians with Oversight MUST:

- **Be a GP or Consultant with responsibility of care, but in some healthcare settings may also be a senior nurse or allied healthcare professional, as designated by the relevant Health Board/Trust**
- **Be clinically registered and familiar with this policy and its latest version.**
- **Must feel competent to hold sensitive communications regarding DNACPR, and be aware of current mental capacity law and code of practice and their application**
- **Ensure appropriate involvement has taken place both with the patient and those close to them, a '<u>duty to consult</u>', unless they feel it could cause harm. This involvement may have been via a colleague who has signed section 5 of the form, so the senior responsible clinician may not have been involved in the discussion per se, but can still conform sign-off of the form.**
- **Ensure proper documentation is in place including, if the person has been judged to lack capacity to engage in decisions about treatment escalation planning/DNACPR, that there is clear documentation that supports this.**
- **Verify a decision made by signing and dating, with their professional registration number (GMC/NMC/HCPC).**
- **Where they are temporarily unable to physically sign a DNACPR form that has been discussed, filled in and signed by a colleague in section 5, they can verify this decision verbally by telephone/video-link, and ask the colleague to document this dialogue on the form and countersign on their behalf.**
- **When doing this, they should also inform said colleague of their GMC/NMC/HCPC number, who can fill it in for them on their behalf in section 6.**
- **In doing so, they agree that the stipulations of the All-Wales DNACPR policy have been met by the healthcare professionals involved in writing the form**
- **They must ensure communication of the decision to the relevant clinical colleagues and Multidisciplinary Teams (MDT) involved in the care of the patient and ensure electronic patient records are updated with this new information, in a reasonable timeframe**

5.8 Senior oversight for every DNACPR decision including out-of-hours

The senior responsible clinician is responsible for overseeing the documentation and communicating decisions. An agreed DNACPR position must be relayed to all senior responsible clinicians involved in an individual's care in a timely manner, with information that a DNACPR discussion has taken place, and an All-Wales form completed and shared with the patient.

Knowledge of advance & future care planning, DNACPR policies, sound communication skill training and mental capacity assessment is essential and must be updated and included in appraisal/revalidation cycles. See also section 9 - Training on DNACPR and community awareness.

If a senior responsible clinician is not physically present at the time of the discussion, the fact that they have been involved and informed (for instance via phone) must be clearly recorded on the form, together with their GMC/NMC/HCPC number.

The process of countersignature is not necessary if a senior responsible clinician has had the original discussion and completed the form. Having two professionals' signatures on the form may improve confidence in the information on the form, in future situations where a clinician who does not know the patient, is given the form (see Audit point 11 and 12).

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

A senior responsible clinician should sign or countersign a completed DNACPR form, *or* ensure that their involvement in the decision is clearly documented on the form together with their GMC/NMC/HCPC number in section 6. They should ensure that consultations with patients and those close to them have taken place or attempted/offered. Out-of-hours, a senior responsible clinician must be available and informed as soon as appropriate that a DNACPR discussion has taken place. In the acute out-of-hours situation the DNACPR discussion will often be undertaken (and the form completed) by a less senior healthcare professional. This decision can be verified remotely between the healthcare professional completing the form who has held the discussion, and the senior clinician (e.g. consultant) who may be unable to sign in person at that time.

5.9 Responsibilities of the senior responsible clinician

The senior responsible clinician who signs or countersigns a form is clinically responsible for the agreed position. This senior clinician has additional responsibilities: to ensure the correct communication with a patient and their significant others, including assessment of understanding of what CPR is and how successful/unsuccessful it may be in every individualised situation. They should help ensure (with other team members) that the needs of those closest to the patient are being met. The senior responsible clinician should also be the reference point for any significant clinical questions or difficulties that might arise relating to a DNACPR decision. They are responsible for the dissemination of the information regarding a DNACPR form and relevant discussions to primary and secondary care plus out-of-hours services and electronic patient records. They can also identify, where appropriate, when a second opinion on a decision may be warranted. A senior responsible clinician may also, after a person has died, be asked to give evidence to a medical examiner, or a coroner, with regard to the nature of DNACPR discussions held.

6. The All-Wales DNACPR Form

6.1 Documentation of DNACPR decisions in Wales

The All-Wales DNACPR Form is the agreed official form for recording DNACPR decisions across NHS Wales after 1 October 2015.

Workshop Comment:

"Primary care must be made aware of all DNACPR decisions on their patients"

All relevant sections of the form must contain entries. It specifically relates to DNACPR decisions and must form an integral part of the medical record. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms must be adequately completed and contain up to date clinical information. The form should be filled out in dark ball-point, with legible handwriting and should also be signed and dated. The completed form can be used in the person's home, in hospitals, hospices, care homes, and during ambulance journeys. For that reason, it is important that the person keeps it with them, and that it is readily available for professionals who may need to see and use it. The person should take it with them if they go out or travel away from their home, and make sure that their family, friends or carers know about it, and know where to find it in an emergency. Clinicians should help people to understand the importance of this.

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

Sections 3 and 4 must be filled in including a written summary of discussions, abiding by the Duty To Consult. Not discussing a DNACPR form that goes into a person's notes if they have decisional capacity, goes against an individual's right of self-determination and choice under Article 8 of the Human Rights Act. If it is not possible to discuss with a person, then the reason must be recorded and all efforts must be made to contact those close to them, and also record these conversations or attempts to get in touch.

"The correct communication of DNACPR decisions is vital to meeting the patient's needs" – Welsh Ambulance Service Trust

If a clinician records on the DNACPR form that a patient lacks capacity to engage in discussions about treatment escalation including DNACPR, then they must have assessed capacity for this specific decision and reference where this information can be found in the records. The level of detail required when documenting capacity assessments is dictated by the urgency of the decision, but it is expected that clinicians will provide evidence of their reasonable belief as to why the person was unable to make the decision, the presence of an impairment or disturbance in the mind or brain, and why this impairment resulted in the patient's inability to make the decision. Please follow local MCA policies and procedures in relation to documentation.

Where the **Welsh language version** of the form is preferred, an English language copy must be appended to ensure that any healthcare professionals not proficient in Welsh can understand all the important content of the form in an emergency. Some trusts and health boards also retain a copy of the form (for instance the Welsh language form) for their 2 yearly audit.

If the person moves from one place to another (e.g. to or from home, hospital, hospice, care home, nursing home or from one hospital ward to another) it is good practice to review the DNACPR form and decision, to ensure that its recommendations remain valid**, but a new form will not automatically be needed (for instance to change the home address to the hospice or care home address) unless the clinical recommendations change.**

6.2 Whole-system recognition of the All-Wales DNACPR form

The All-Wales DNACPR form is recognised across all NHS sectors in Wales. This includes older versions of the form, for instance versions from 2015, but review of forms is recommended and on occasion, the patient and their healthcare professional may feel that a newer version of the document should be filled in. When a DNACPR decision has been reached, **a signed and dated All Wales DNACPR form should be offered to the patient,** or the person important to the patient / their advocate at the time, and a further form or copy must be prominently placed in the patient's health record with copies relayed to other parties (see section 6.4). Photocopies/marked copies are acceptable where they are clear and legible, but when they are received in a new healthcare setting (e.g. hospital transfer) can be further clarified/verified via handover processes and/or by contacting the original signatories and senior responsible clinician. If a DNACPR form received from elsewhere is unclear or illegible, the accepting clinician should talk to the patient and/or seek clarification from the previous clinical team, and can then fill in a new form, referencing previous discussions/notes and forms.

6.3 The completed DNACPR Decision

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

Audit point 13 – Completing the All-Wales DNACPR form

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

6.4 Data capture, language and communicating the DNACPR Decision

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

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

1. DNACPR form or legible copy should be prominently placed in the **patient's healthcare record. Electronic patient records/alerts should be updated and should give detail of the form, including scanned copies of the form**
2. A **DNACPR form** should be offered (and if in agreement) then given **to the patient, the person important to the patient, or their advocate at the time** for personal ownership prior to discharge.
3. A **copy** should be **forwarded to the patient's GP who should retain the paper copy and ensure that the DNACPR decision is recorded electronically in the patient notes, including a scanned copy. The GP must also inform the out-of-hours provider/the care home.**
4. A copy should be handed to ambulance personnel when transported from a hospital setting.
5. Where the Welsh language version of the form is preferred, an English language form must be available and appended, to ensure that any healthcare professionals not proficient in Welsh can understand all the important content of the form in an emergency (see also section 6.1)

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

1. A version of the filled-in DNACPR form (e.g. *Healthcare Copy*) should be **retained by the patient's GP, who should place it in the medical record, record it electronically and inform the out-of-hours provider.**
2. The DNACPR form (*Patient Record*) should offered **to the patient or the person important to the patient or their advocate at the time for personal ownership.**
3. When relevant **a form or legible copy** should be retained in the records of the care home.
4. A form/copy should accompany the patient whenever care transfers to secondary care, to be entered into their case record.
5. Where the Welsh language version of the form is preferred, an English language form must be available and appended to ensure that any healthcare professionals not proficient in Welsh can understand all the important content of the form in an emergency.
6. Ambulance control should also be informed of the existence of a DNACPR form at the time of booking an ambulance. Whenever possible a copy should be handed to ambulance staff when being transported**.**

- ***When at home: How do people know that there is a DNACPR form or other Advance/Future Care Plan in someone's home?***

In a home situation, there is the so-called '**Message in Green Bottle' Lions/Rotary Club scheme**, with a sticker inside the front door, and it is well established in Wales: paramedics look for a green sticker inside the front door routinely when they go on house calls, which alerts to the presence of a green bottle in the person's fridge. Then they know there is something important they have to check for. Anyone can put their DNACPR form or an ADRT/Advance & Future Care Plan in a green bottle in the fridge, or a written instruction as to where to find all these important forms in the house ("My DNACPR form and Advance & Future Care Plan is in living room in bottom left shelf"). The Lions and Rotary Clubs supply the bottles to health centres, GPs and chemists in Wales, but other green bottles can also be used. The green Lions and Rotary Club bottles and stickers are also available directly from the organisation (0845 833 9502 for details of local organisation). See: http://advancecareplan.org.uk/welsh-ambulance-service-trust/ and: https://lionsclubs.co/MemberArea/message-in-a-bottle

- ***ACP Flag on Welsh Clinical Portal***

Where a patient has been consulted and is in receipt of their DNACPR (and other advance & future care plans), the clinician can tick the ACP flag on Welsh Clinical Portal, to alert others that a discussion has taken place on a certain date. Anyone who at a later stage sees this ACP flag can be prompted to ask patient or those close to them, and also check contemporaneous clinical note entries against the date that the ACP flag was raised on Welsh Clinical Portal. Further information can also be obtained from the Patient Preferences Form on Welsh Clinical Portal, including information with regards to a person's wishes towards the end of life.

Audit point 14 – Communicating a DNACPR decision

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

Communication with those closest to the patient must be unhurried, undertaken with patience, tact and with sensitivity for the situation. Explanation of what to do in emergencies at home, including who to call, and schemes such as the 'Message in a Green Bottle' scheme at home, as well as the ACP Flag and the Patient Preferences form on Welsh Clinical Portal, can be outlined and clarified in further conversations, as appropriate.

7. Review of a DNACPR decision

7.1 Review of a DNACPR decision

The national nosocomial Covid-19 end of programme report 2024 in Wales called for better review processes of existing DNACPR decisions after it looked into practices during the pandemic. Many DNACPR forms can be seen as enduring documents, as they are filled in when someone is approaching the last months/years of life, with co-morbidities that will likely render CPR unsuccessful. Many patients may not wish to repeatedly review and discuss this topic. However, as already covered in this policy, there may be times when a DNACPR decision is reached during a severe illness which makes a patient sick enough to die in the next days or weeks, for instance when there is a severe pneumonia or sepsis. If the person recovers and improves, then a DNACPR decision can be reviewed and revoked/cancelled. When necessary a review should be planned and envisaged, and then subsequently undertaken by a clinician actively involved in the care of the patient. When a review has taken place this should be recorded in contemporary notes and the segments and dates in the top left section of the all-Wales form *('Date of DNACPR Discussion – If above statement does not apply & this form is short-term-only only, please specify review date:… Outcome:* ….') should be added/updated. We have modified the DNACPR form for version 5 of the policy, to reflect that usually decisions are valid until the end of life;

however, review dates and their outcomes can be added to the top left of the form, if clinicians or teams feel the decision is temporary, for instance during a severe sudden illness that may lead to a NAAD.

DNACPR, unless specified, do not have a specified date at which point they are no longer valid. Some patients have their DNACPR forms with them for several years. A DNACPR decision review should always take place if it is, for instance, requested by the patient. A review of the DNACPR decision should also be clinically considered when a patient's overall condition **significantly improves**, warranting further discussions. The details of the review should be recorded in the patient's clinical record and the date/outcome recorded on the All-Wales form. If the clinical circumstances **clearly** change, a decision can and should be cancelled (see section 7.3), or a new form may need to be completed that has more up to date information. This decision will be subject to the same information sharing as the initial decision, ensuring the updating of all records with the new copy of the DNACPR form and, again, a copy of the new form must be handed to the patient or the person important to the patient, or their advocate/deputy at the time.

Other opportunities to discuss and review a DNACPR decision:
It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round
- MDT or Gold Standards/palliative care meeting
- On transfer of medical responsibility (e.g. hospital to community handover or vice versa);
- or whenever there are significant changes in a patient's condition
- It should be discussed if requested by a patient, those close to them, or another clinician who wants to review this decision (see below for urgent reviews as well)

7.2 Urgent DNACPR reviews

All patients must feel able to request a review of a DNACPR decision at any time. This includes those patients with diminished and/or fluctuating mental capacity for this decision, where either those close to them or named family members/significant others can request a review. **All such requests must have urgent status**. In some cases, an unforeseen, sudden and *sustained* improvement in clinical status can occur and a review of the position becomes necessary. In such circumstances, once clinically recognised, a review must take place. See section 7.1.

To state the obvious, it should be remembered that even when there is overall improvement in an individual's health, the success of future CPR, should it ever become necessary, is likely to still remain very low or non-existent. The decision has to be individualised and depends on the circumstances; many people with multiple long-term conditions may still prefer to retain their DNACPR forms, due to the low likelihood of success of future CPR, when their heart and breathing have already stopped working. But they can continue with any other treatments they require and are deemed necessary and can carry on as normal a life as possible, with the form accompanying them.

Audit point 15 – DNACPR review

All patients with an agreed DNACPR decision can have a clinical review as part of the normal course of events of their condition(s). Efforts should be made to ensure that patients and those close to them are aware that a request for review of a DNACPR decision can be made at any time.

7.3 Cancellation of a DNACPR decision

In some circumstances it may be appropriate to cancel a DNACPR decision. If this is necessary then the original form should be clearly crossed through with 2 diagonal lines in black ink with

“CANCELLED” written between them. **The relevant section (section 7) of the form must also be completed and signed by a clinician. Senior responsible clinicians involved in the care must be consulted and informed if they have not initiated the cancellation themselves. All previous recipients of the DNACPR decision form (including those listed on the form) must be notified immediately that the decision has been cancelled.** The communication must be in writing and logged in all relevant records and where possible, contain a copy of the overwritten cancelled original document. The patient’s own form should be returned and filed in an envelope in the case record to reduce risk. If destroyed this must also be recorded.

In situations when the original form is not available (for example, a GP only has a scanned computer record of a hospital DNACPR form, or a patient has lost or destroyed their own original) but there is an imminent review of the decision, then the following action can be taken: If the review with a patient concludes that prior DNACPR decision should now be cancelled, the healthcare professional can rewrite a DNACPR form cross-referencing the previous discussion on the new form (“*DNACPR discussion previously held with hospital consultant Dr AW on 23/03/2020 and patient agreed that would not want CPR administered during acute deterioration* ***at that time***”). They can then cancel this form adhering to the guidance in the first paragraph of section 7.3 and signing it with the contemporaneous date, thereby making it the most recent form. Whilst somewhat onerous, this is then as clear an indicator of cancellation as is possible and becomes the latest record. This should then be disseminated to all involved, and a detailed record of the consultation should be made, and distributed as necessary.

If an electronically scanned DNACPR form/PDF file is on a person’s electronic clinical record (such as Welsh Clinical Portal/ WCP) and is subsequently cancelled, it can be marked as ‘misfile’. This means it will no longer be visible, but can still be obtained at a later point, for instance for review or audit purposes.
Typically, the clinician selects the document they wish to misfile

1. Click full screen (Bottom right)
2. Click ‘*Mark as misfile*’ (Bottom left of full screened document)
3. Enter the reason e.g. “DNACPR decision no longer applies, and patient and family are aware” and enter password.
4. The reason for misfile is visible in the electronic document history.

Other systems such as ‘Emis’ will likely have similar procedures, and clinicians should check with their Local Health Board or Trust’s procedures to ensure this is done correctly.

8. Special circumstances related to DNACPR

8.1 DNACPR decisions and high-risk invasive procedures

When individual patients are very unwell some pre-planned invasive procedures may substantially increase the risk of a cardiopulmonary arrest (examples include general anaesthesia, a pacemaker insertion, cardiac catheterisation, or surgical procedures). When such interventions are being contemplated for patients with an agreed DNACPR in place, the “current DNACPR position” must be reviewed with the patient in advance of the procedure (see also section 5.1.2). A decision to suspend the decision temporarily must be communicated with the patient or the patient’s representative (if the patient has reduced mental capacity) and the wider clinical team and recorded.
Some patients may want an agreed DNACPR decision to remain valid, despite the increased risk of a cardiopulmonary arrest and despite foreseen potentially reversible causes; others may agree that the DNACPR decision should be suspended temporarily, if for instance a cardiac arrest rhythm emerges during the procedure as a direct result of the procedure, and shocks are easily applied at the time. A decision as to how to proceed with the procedure in such cases is a matter for professional judgement and must follow informed discussion.

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

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

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

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

8.2 Unpredictable, unforeseen and reversible clinical events

A DNACPR form is **not** an absolute mandate and can be overridden if it is reasonably believed that the circumstances of the cardiopulmonary arrest were not considered when the DNACPR form was created. In clinical practice such unpredictable emergency situations can occur in patients who have a current DNACPR in place. These include for example, acute, unforeseen and immediately life-threatening situations such as reversible anaphylaxis, choking on food, or a completely blocked tracheostomy tube. In such instances, the underlying cause requires maximal treatment and temporary 'CPR' and also first aid (to remove a food item from the back of the throat), might become necessary whilst any reversible cause is correctly managed. For instance, where a blocked tracheostomy tube is cleared, this may be seen as a form of airway CPR, but it is also clearly an urgent comfort measure for the patient, in a potentially reversible situation that requires an immediate response. An existing DNACPR form is therefore never a reason not to think carefully: always fully consider the individual situation and emergency providers must respond immediately and without any prejudice of the situation.

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

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

8.3 A clear request for CPR – when CPR is not likely to be successful or clinically indicated

A patient might insist that future CPR is to be provided - even when (for clear clinical reasons) the clinical team feel it to be an intervention which cannot provide clinical benefit and will not be successful. When a patient requests CPR following a discussion that clearly outlines very significant risks and burdens, the senior clinician must record fully the patient's expressed wishes, alongside their own clinical views. **When conflict exists and whilst further advice is sought, the interim position should normally be to call the emergency services or arrest team in an arrest situation, to consider CPR under current circumstances on arrival, as appropriate for the emerging circumstance.** Efforts should quickly be made to reconcile the position if at all possible. In some cases, a multi-professional team review might resolve to follow the patient's wishes in an individual case, and to provide CPR, even if it is felt that it will not work or even potentially cause harm. In other situations, however, the conclusion might be that attempting CPR in the circumstances would be clearly contrary to best clinical judgement and good practice. **In such cases, a second opinion must always be offered,** and legal advice may become necessary with further discussion with the patient. When there is serious challenge to a DNACPR position, from whatever quarter, the legal and ethical position must be considered. Healthcare professionals, who take a fully considered ethical and clinical position, should immediately share and document their concerns and receive support from their organisation.

A close relative, named supporter or main carer might also openly express disagreement with a decision not to provide CPR. In such circumstances, you must respect and listen to the concerns. A review by the team should take place. If the original position of the team is upheld, then a second independent senior clinical opinion may be advisable depending on individual circumstances, but with the knowledge and consent of the patient. However, a relative's wishes cannot override the agreed position that has been reached by the patient and the clinical team. This is also the case when a patient has lost capacity for this decision but has *previously* expressed that they would not want CPR, but where a relative, main carer, or person close to the patient disagrees and insists it must now be given if an arrest or natural anticipated and accepted death occurs. Such requests must always be handled with utmost respect and sensitivity. Many people may have unrealistic expectations of what CPR can achieve, or hold a fear that care is being taken away. Many patient/carer representatives have stated that there is a fear amongst members of the general public, sometimes due to media reports on the matter, that DNACPR forms may be seen as "Do Not Provide Any Care" forms, Patients and those close to them must be reassured that this is not the case, and that it is merely CPR that is being discussed.

Audit point – 16: DNACPR case for automatic review –Example 3

It should be considered an "exceptional clinical event" to pursue a DNACPR position that is contrary to the expressed views of the patient

When a patient states a request for "full CPR", and this is clearly contrary to the unanimous judgment of the clinical team, this should be urgently re-considered by the clinical team and an attempt made to reconcile the position. A second senior clinical opinion should be sought. In exceptional circumstances legal advice may be necessary. All such cases should be subject to reflection at a later audit and/or serious clinical incident event, to facilitate team and organisational learning. Audits, mortality reviews, Datix reports and significant event meetings with regard to CPR/DNACPR decisions, should be fed back to Quality & Governance Boards in health boards, to ensure action is taken in each individual case.

8.4 Patients with Implantable Cardioverter Defibrillator Devices (ICDs)

Patients with a DNACPR decision in place, who also have an Implantable Cardioverter Defibrillator device (used to treat life threatening arrhythmias) require particular consideration. Such devices, even in circumstances where shocks to the heart may not be wanted, can apply electric shocks up to 30 times. The decision as to when to deactivate the device requires careful planning and discussion between senior clinical colleagues (with expertise in ICD usage), the patient and those closest to them. In emergency situations teams must consult policies or discuss with on call experts as to how to temporarily deactivate a device. All processes of informed consent and consultation with patient and close relatives apply to this element of care.

In Wales, the **All-Wales Cardiac Network** has provided an All-Wales Operational Document for the **Deactivation of Implantable Cardioverter Defibrillators (ICDs) at the end of life (version 4)**. It provides an all-Wales approach for devices with up-to-date guidance, including local contacts in all parts of Wales, communication suggestions and a deactivation of ICD form. Version 4 (please always check for more up to date versions) can be found here, amongst other key documents: https://executive.nhs.wales/functions/networks-and-planning/peolc/documents/ (see also in "References")

When patients have an ICD in place and a DNACPR form has been filled in, special notice should be provided in the free text section of the DNACPR form, with reference to more detailed information about conversations held and plans made. It is important to note that different ICDs have different deactivation mechanisms. Patients may also need careful explanation that deactivation of an ICD will not cause any *sudden* deterioration, it merely ensures that there are no future automated electric shocks when a patient deteriorates.

8.5 When clinical care extends between health sectors or across borders

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

It is recognised that patients may be repatriated from cross-border providers. When a patient transfers to Wales with an active DNACPR decision, the All-Wales DNACPR Form should be completed with reference to the prior discussions held and forms completed within 14 days. The form that has transferred over, or a clear, legible copy, can be appended to the All-Wales DNACPR form. During that 14-day period (and even beyond), the original cross-border decision/form remains a part of the person's health record and cannot be ignored. It must form part of any relevant decision processes.

All forms in the UK, including the **ReSPECT** form in England and DNACPR forms from Scotland or Northern Ireland, constitute a valid clinical record of a prior decision-making process, when they have been filled in clearly and conscientiously. They inform a clinician of any important decisions and discussions that have previously occurred. They are essentially a clinical correspondence from another clinician working elsewhere and should be treated as such. Whilst DNACPR forms (including the All-Wales DNACPR form, the ReSPECT form and other UK forms) are not legally binding, all such forms should constitute a part of the overall decision-making process and weighing up of information to guide emergency situations, where these occur. Even where the 14-day period outlined above is breeched**, it is crucial to take into consideration any form that has accompanied a patient and give it appropriate weighting in each decision making process.**

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

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

DNACPR forms where a person other than a GP or Consultant has signed the Senior Responsible Clinician section 6 of the All-Wales DNACPR form, for instance a nurse consultant, should be given the same weighting in any new Health Board or Trust that they transfer over into, even if that healthcare setting does not have the same process of nurse consultants or consultant AHPs signing DNACPR forms. This is a national policy for all of Wales, therefore local variances in practice can be addressed by reverting back to the contemporaneous version of the DNACPR policy document.

8.6 Emerging situations where there is no DNACPR form or Advance & Future Care Plan

In situations when there is no DNACPR form or other Advance & Future Care Plan such as an ADRT in place, and the clinician attending is as clear as they can be that the person is dying or has already died, the regulating organisations (GMC, NMC and HCPC) have issued individual guidance that CPR does not have to be automatically given on scene by default. For instance, where an arriving team feel CPR will not help, cause significant harm with no benefit, or is not indicated, cardiopulmonary resuscitation in the absence of a DNACPR or similar form, need not be given. The Nursing and

Midwifery Council together with the British Medical Association and Resuscitation Council, has released the following guidance, as part of their Decisions Relating to Cardiopulmonary Resuscitation Guidance (previously known as the 'Joint Statement' : "*There will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded. Also, there will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies*." [NMC, BMA and Resus Council UK]

8.7 Organ donation

Discussion with regard to organ and/or tissue donation can be considered in line with the current All Wales policy and is not uncommonly brought up by patients themselves. Sometimes this comes up as part of DNACPR and Advance & Future Care Planning conversations. This should be sensitively explored if felt appropriate. More information: https://gov.wales/organ-donation

Nursing and Midwifery Council UK Statement 2020:

"If, as a health and care professional, you are faced with making a decision about CPR when an explicit DNACPR decision is not available, you should be supported if you make a careful, considered decision not to start inappropriate CPR."

https://www.nmc.org.uk/news/news-and-updates/reflections-on-recent-cpr-fitness-to-practise-case/

9. Training on DNACPR and community awareness

DNACPR training applications, **emphasising the importance of good communication with patients and those closest to them**, should be made available via Local Health Board and Trust intranet systems for instance via *ESR (Electronic Staff Record)* and *Learning@Wales*. Local Health Boards and Trusts can also decide to make this part of mandatory training for relevant staff. Staff should be encouraged to complete for instance the e-learning programme 'End of Life Care for All' (e-ELCA), which includes modules on DNACPR communication and advance & future care planning and can be found in ESR. Local training should clearly outline this policy and facilitate access to further DNACPR information, such as the http://talkcpr.wales resources. Local Health Board and Trust clinician induction programmes across Wales must raise awareness of this policy and learning resources. Primary care professionals must be offered access to training provided by Local Health Boards and Trusts. It is vital that evidence is provided that this policy straddles the "whole system of care" and hence all relevant NHS staff should have easy access to knowledge bases, senior clinical support and to the training necessary in order to deliver an effective system for DNACPR conversations. **The training needs to ensure awareness of the personal, individualised and specific nature of these decisions with awareness of the needs of patients.** It is recommended that those undertaking senior responsible clinician roles across the NHS in Wales, especially clinicians who may undertake such DNACPR discussions routinely, should undertake regular education on DNACPR as part of their professional competencies and appraisal/revalidation cycles, and that this should be evidenced and discussed in their reviews.

It is essential that those undertaking roles related to this policy in all community settings have access to practical work-based training and education (provided for instance by Resuscitation Officers based within Local Health Boards, or GPs with special interest in Palliative Care as part of Advance & Future Care Planning and DNACPR study days). Training in such areas should place some importance on the evidence and basis of knowing how effective CPR is in different situations, when *not* to provide CPR, as well as providing practical training on the performance of CPR. This training relates also to all ambulance paramedic staff with responsibility for the provision of CPR and in Wales the Serious Illness Conversation Cymru programme has reached hundreds of paramedics, who often contribute to end-of-life-care in community settings and have significant conversations. Welsh paramedics as part of their undergraduate programmes in Swansea now also have routine end of life care teaching and have been joining palliative care teams across Wales. Local Health Boards and Trusts are well placed to develop and maintain a register of those individuals who have received training in DNACPR discussions, implementation of this policy and mental capacity regulations. Regulatory authorities for Wales should be made aware of this and might consider this as part of their monitoring of standards in community settings.

Examples of available modules via ESR, e-ELCA and Learning@Wales:

- ESR: National DNACPR Policy for Wales (ESR Link) also available on Learning Wales
- 000 e-ELCA 10-12 Advance Care Planning Principles, Context and Process
- GP CPD on Demand All Wales DNCPR Policy: https://gpcpd.heiw.wales/cpdon-demand/
- All Wales E-Learning on ESR: 000 NHS Wales - Mental Capacity Act - Level 1
- 000 NHS Wales - Mental Capacity Act - Level 2 (additionally, each UHB will offer regular additional mental capacity training locally)
- General Medical Council: Mental capacity toolkit Mental capacity - GMC (gmc-uk.org)
- DNACPR and learning disability: Turning Point & Learning Disability England Information Pack and resources regarding DNACPR https://www.turning-point.co.uk/_themesdelivery/content-delivery/assets/dnacpr-content/dnacpr-information-pack/content/index.html#/
-
- 000 e-ELCA 3.3 Communication Skills specific contexts (includes discussing potentially difficult situations in end of life are, plus law and ethics in palliative care)
- 000 e-ELCA 3.4 Communication Skills challenging scenarios in DNACPR discussions
- 000 e-ELCA 4.5 Symptom management last days of life, communication skills and recognising dying
- 000 e-ELCA 5.0 Integrating learning, initiating conversations about end-of-life care
- E-Learning for Healthcare Discussing Unwelcome news https://portal.e-lfh.org.uk/LearningContent/LaunchForGuestAccess/611119
- End of Life Care (e-ELCA) > e-ELCA 03 - Communication Skills > Discussing 'Do Not Attempt CPR' Decisions : https://portal.e-lfh.org.uk/Component/Details/1939
- **More education links on www.wales.nhs.uk/DNACPR under Education/ESR/CPD/Modules and further link here: https://executive.nhs.wales/functions/networks-and-planning/peolc/documents/nhs-wales-resources-dnacpr-and-afcp/**

10. Measurement and Clinical Audit in NHS Wales

10.1 Audit of DNACPR in Wales

All health boards and trusts in Wales participate in audit of DNACPR processes every 2 years, and have been subject to inspection of these processes by Health Inspectorate Wales, for instance during 2024 (see ‘All Wales report on DNACPR by Health Inspectorate Wales' report in references). Audits are usually undertaken by resuscitation officers in each health board and trust, who also sit on the All-Wales AFCP Group. Results of audits are fed back to each health board or trust’s quality and governance structures. Many health boards and trust now complete their clinical audit on electronic provider systems such as AMAT (Audit Management and Training). Because each health board’s resuscitation officers also send a representative to the All-Wales AFCP group, any problems identified at regional audit can also be discussed at national level, swiftly and pragmatically.

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

The grey boxes throughout this policy highlight those areas that can be focused on.

This All-Wales DNACPR policy may have impacts in a number of areas in relation to the following:

10.1.1 Processes and NHS administration

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

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

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

“An effort must be made to cross reference incidents with complaints and investigations on DNACPR” (Dignity revolution)

10.1.3 Communication and Teamwork

- Understanding responsibilities re: DNACPR roles within clinical teams
- Evidence of appropriate oversight by a Senior Responsible Clinician

- A **duty to consult** in a transparent, candid and appropriately sensitive way with patients regarding any DNACPR decisions, but also an understanding that for some patients this communication may cause harm (e.g. psychological), and should not proceed
- Evidence of multidisciplinary team decision making in the DNACPR process
- Evidence of correct communication across sectors including primary care, out-of-hours and emergency care systems
- Evaluate need to move from paper format with its inherent risks, to an electronic patient record system, ideally a central electronic repository for advance & future care plans and DNACPR forms, for patients in Wales that can be uniformly accessed by healthcare providers.
- Appropriate use of Advance Care Plan Flag on Welsh Clinical Poral to indicate that a discussion has taken place (and when)
- Local processes to ensure any forms that are uploaded to electronic patient records are readable/findable. And that they can be reversed if a DNACPR form is cancelled.

10.1.4 **Privacy, culture, dignity and respect for patients and those close to them**

Several reviews of DNACPR processes across Wales have taken place in recent years, including a detailed Health Inspectorate Wales review, a national Mortality Review Group Thematic DNACPR Review, and the national Nosocomial COVID-19 Programme (NNCP) for Wales (see references). In 2023 all health boards and trusts in Wales took part in a thematic review on DNACPR, initiated by the NHS Wales Executive Performance and Assurance Quality and Safety Division, in conjunction with the All-Wales Mortality Review. Each local health board has adopted the national DNACPR policy, and therefore has to ensure that there is a rolling programme of audits for DNACPR and Advance & Future Care Planning practice (minimum every 2 years) usually led by local resuscitation officers. Any outcomes, challenges and action plans are then presented to local HB/Trust Quality & Safety Boards (or equivalent clinical governance organisational oversight structure), and also staff involved, in order to swiftly address findings. Resuscitation officers in each health board also sit on the national AFCP Group.

The thematic review concluded the need for ongoing focused education, highlighting the many existing education resources (including ESR) that have been disseminated to health boards and trusts.

This was echoed in the national review report on DNACPR by Health Inspectorate Wales (HIW) in 2024, who scrutinised practice, forms, documentation and also reviewed each health board and trusts last 3 DNACPR audits over the last 8 years. HIW also surveyed the wider public and clinicians and concluded that consideration for individuals' spiritual needs, values, and belief (culture, religion etc) was an important part of the process, but also could form part of QI and audit processes. Such information on cultural/religious aspects of DNACPR (for instance some cultures erroneously conflate DNACPR with euthanasia, which is forbidden in religions like Islam), should be more readily accessible and can be considered by all clinicians involved in a person's care. The All-Wales AFCP Group have made resources available, including information about DNACPR decisions for people of Muslim faith, and have worked with Muslin Doctors Cymru to improve dissemination. Further resources can be found via www.wales.nhs.uk/dnacpr

A Hospice UK Report **'I just want to be me' – Trans and Gender Diverse Communities' access to and experiences of palliative and end of life care, highlighted fears of discrimination.** We have provided references and education resources (including a TalkCPR/Compassionate Cymru video/podcast) which highlights these areas and encourages further awareness in Wales. Find it here: https://compassionate.cymru/2024/06/28/in-conversation-about-trans-and-gender-diverse-communities-and-experiences-of-end-of-life-care/ and in references.

We have also recorded a podcast with patient/carer representatives, including **Bereaved Families For Justice Cymru Covid-19 Inquiry Group**, which can be found as a TalkCPR resource: TalkCPR podcast, talking to Bereaved Families For Justice Cymru and patient representatives about DNACPR decisions, and when things can go wrong.

We have also provided learning resources on our www.wales.nhs.uk/DNACPR with regard to learning disabilities and how important it is not to discriminate and prejudge. This DNACPR policy covers people who have life-limiting palliative illnesses, and where end of life discussions may be required, such as in advanced cancer. Diagnoses such as autism or learning difficulties should therefore never be listed in the Clinical Summary of Conditions and Reasons why CPR would not be successful. A helpful video can be found here: "Palliative Care for People with Learning Disabilities PCPLD 2021 Conference: DNACPR & Advance Care Planning". Furthermore, Learning Disability England, together with Turning Point have put forward a learning resource for people with a learning disability to understand DNACPR, including how to contest a decision. https://www.turning-point.co.uk/_themesdelivery/content-delivery/assets/dnacpr-content/dnacpr-information-pack/content/index.html#/

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

These elements can form the basis of a local DNACPR audit template, and auditors may wish to consider the question: 'Does the Health Board/Trust have a designated site for education resources with regard to cultural aspects around DNACPR discussions?' Local Health Boards ad Trusts using all Wales DNACPR forms and policy are expected to assess performance against these headings every 2-3 years, usually carried out by resuscitation officers.

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[Appendix sections below this page]

Appendix A: The All Wales DNACPR Form (page below to allow for full page views)

All-Wales DNACPR Form (Adult 18+) DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) DISCUSSION

Date of DNACPR Discussion: / /

This recommendation is *generally* valid until end of life, (unless cancelled, see policy and section 7) If not:

If above statement does *not* apply & this form is short-term only, please specify review date: / /
Outcome of review &signature/date/GMC/NMC/HCPC no:

Name:
NHS/Hospital No:
Date of Birth:

Home Address:

THIS FORM **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. Does the patient have capacity to participate in discussions about treatment escalation & CPR? YES / NO

If "NO" reference your written assessment in health record. Consult those close to patient. Also:

Are you aware of a valid Advance Decision to Refuse Treatment (ADRT) refusing CPR which is relevant to the current situation? If YES, append a copy YES / NO

Has the patient appointed a Health & Welfare Lasting Power of Attorney to make decisions on their behalf? If "YES" they must be consulted. YES / NO

2. Summary of main clinical conditions & co-morbidities & reasons why CPR would not work, or be inappropriate, or not in the patient's best interests (for example: 'Cancer with widespread metastatic disease')

Clinical Summary (You must fill this in for this form to comply with All Wales DNACPR policy standards)

Select reasons that apply to this individual situation:

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

3. DUTY TO CONSULT Has a discussion taken place with the patient? YES / NO
Please summarise decision below. If NOT discussed, please record reasons, e.g. potential for harm from discussion. & also discuss with those close to patient (box 4):

Summary of discussion or attempts to discuss (must be filled in to comply with All Wales policy standards):

4. Has appropriate discussion taken place with those close to the patient, a Health and Welfare Attorney or an IMCA? Please also record *unsuccessful* attempts to contact them in box. YES / NO

Name of person:...
Relationship to patient:...

Summary of discussion i.e. attempts to discuss & how contacted (must be filled in to comply with All Wales policy standards):

5. Healthcare Professional completing this form (must inform Senior Responsible Clinician who signs or remotely confirms section 6):

Name (PRINT):...
Position:...
Contact Details:..
GMC/NMC/HCPC no:.... ……………

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

6. Senior Responsible Clinician with oversight to sign or remotely confirm below:
(SRC ensures MDT/others involved in care are made aware of decision – record recipients in section 8)

Name (PRINT):...
Position:...
Contact Details:..
GMC/NMC/HCPC no:.... …………….

Signature...
Date: ……/……/…… Time:………
(can include proxy signature if SRC consulted remotely, but add SRC's registration number above)

7. CANCELLATION of decision: NB: Cross form out clearly twice and write "CANCELLED" across form – notify ALL copy holders & upload a cancelled form electronically if prior forms uploaded (see details below & policy for more)

Name (PRINT):...
Position:...
Contact Details:..
GMC/NMC/HCPC no:.... …………….
Signature:...
Date: ……/……/…… Time:…………

8. COPIES of this form shared with/sent to:

1. ☐ **Patient /Carer** ……………………………………
2. ☐ **GP/Consultants/Clinicians** ……………………………………
3. ☐ **Care Home** ……………………………………
4. ☐ **Out-of-hours providers** …………………………………

This All-Wales DNACPR form is an agreed document detailing a recommendation & is not legally binding; the decision may change according to clinical circumstances.

In the event of a cardiorespiratory arrest/natural death, no attempts at cardiopulmonary resuscitation (CPR) will be made, except in circumstances as outlined in the All-Wales policy (www.wales.nhs.uk/DNACPR). All other appropriate treatment and care will be provided.

- The patient's full name, date of birth and address must be **written clearly with ballpoint pen,** or an addressograph must be attached to each copy of the form. The patient's home address remains valid, even when transferred to other settings including care homes.
- The decision must be dated & communicated to all parties involved in the current care of the patient.
- Many DNACPR decisions are valid until the end of life, and the form specifies this. However, clinicians can specify a review date and outcome.
- The patient's clinical and DNACPR status should undergo review if circumstances change or on request. If reviewed, please record outcome clearly and take appropriate action.

1. Capacity/Advance decisions

If the patient does not have capacity to participate in, weigh up and retain details of a treatment escalation or DNACPR discussion, please ensure that an **appropriate assessment** is recorded in notes, in line with local policy. Ensure that any existing Advance Decision to Refuse Treatment or LPA document is specific and valid and applicable to the patient's current circumstances. Second opinions and legal advice can be considered in the event of disagreements, as recommended in the All-Wales policy. All other decisions must be made in the patient's best interests and comply with current law. Advance & Future Care Plans available via www.wales.nhs.uk/AFCP

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

Please be as specific as possible. The conditions should be those that are deemed to ultimately lead to a natural accepted & anticipated death, see policy for details. More detailed information can be recorded in the patient's healthcare record.

3. Summary of individualised communication with patient

State clearly what was discussed and agreed. If the decision was NOT discussed with the patient, clearly state the reason why, for example 'would cause severe psychological harm'. If interpreter is used they must be approved by the organisation. Writing detail in free text boxes ensures more clarity for all concerned. "Sharing and Involving" Information Leaflet (bilingual) should be offered to patient/proxy, and also www.TalkCPR.wales videos.

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

If the patient does not have mental capacity to participate in DNACPR discussions those close to the patient must be consulted and may be able to help by indicating the patient's recent wishes. They **should not be asked to make** the decision to withhold cardiopulmonary resuscitation - this is a clinical recommendation and decision. But they can inform what the patient's views and wishes with regard to a specific decision may have been. If the patient has made a Lasting Power of Attorney for Health & Welfare, ensure that it is registered. If the patient has appointed a Health & Welfare Lasting Power of Attorney, ensure that this is registered. If valid, that person must be consulted. They may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the Lasting Power of Attorney document. If the patient has capacity - ensure that discussion with others is with their consent and does not breach confidentiality. More detailed description of such discussions should be recorded in clinical notes.

5. Healthcare professional completing the DNACPR form

This should be a member of the clinical team who is up to date with the patient's current medical details and has read the All-Wales policy, including the segment on who can fill in these forms. They should hold a GMC/NMC/HCPC number, it should be in their scope of practice and agreed by their health board for NMC/HCPC number holders. **The signed form records a DNACPR decision when a healthcare professional signs and dates the form and provides their registration number.** The decision must be overseen by a senior responsible clinician (usually the patient's Consultant or GP, and in some settings a nurse consultant or senior clinician with oversight e.g. consultant allied healthcare practitioner). Senior responsible clinician should be informed as soon as reasonably possible. Remote signing off is possible, see policy for details.

6. Details of the senior responsible clinician (SRC) involved in the decision

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

7. Cancellation of the decision

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

8. Communication of the Decision

Ensure individualised communication of a DNACPR decision. Wherever possible patient (or person close to patient) should receive a version of the completed form. Any Welsh language copy should be accompanied by an English language copy, for healthcare providers whose main language is English. If completed in a hospital setting, a legible copy of the form must be sent to the GP/other clinicians involved on discharge. If completed in the community setting, communicate the decision to OOHs and/or care home as relevant.

The All-Wales DNACPR policy & resources can be found and downloaded bilingually at: www.wales.nhs.uk/DNACPR (an NHS Wales Executive site) and is accessible to the public. Patient/carer representatives were involved in its creation throughout.

Appendix B: Example of DNACPR Form Audit Data Collection

For the purpose of clinical audit to inform organisations of progress against criteria set out by the All-Wales DNACPR policy, the following basic data can be collected to review filled-in DNACPR forms, in addition to other data collected.
Please note that this is only an example, and that other metrics, for instance availability of teaching events and study days on DNACPR in last 12 months in the organisation, and completion of ESR modules by staff, should also be assessed. Organisations should set out to review 50 DNACPR forms as a minimum approximately every 2 years.

Criteria	**Standard**
Patient Identifiers	
Name	100%
Date of birth	100%
Address	100%
Date of DNACPR discussion	100%
DNACPR decision (section 1 and 2 on form)	
Assessment of capacity	100%
Clinical Summary filled in	100%
Reason for decision	100%
Discussion with patient (section 3 on form)	
Either summary of discussion *or* reason for not discussing such as 'harm'. Should include free text section on discussion held	100%
Discussion with proxy (section 4 on form)	
Either summary of discussion *or* reason for not discussing such as 'harm' Should include free text section on discussion held	100%
Identifiers of person completing the form (section 5)	
Signed	100%
Name printed	100%
Position	100%
Date	100%
GMC/NMC/HCPC number	100%
Senior Responsible Clinician Endorsement (section 6)	
Name Printed	100%
Position	100%

Date	100%
GMC/NMC/HCPC number	100%
Cancellation (section 7) Please ONLY complete this audit section if DNACPR form(s) within data collection has/have been cancelled *Of all* ***cancelled*** *forms in this audit, please indicate percentage where:*	
Form crossed out clearly	100%
'Cancelled' written onto form	100%
Record of all copy holders being notified of cancellation	100%
Copies of DNACPR Decision (section 8)	
Recipients filled in	100%

A key feature of the DNACPR form is a mandatory text box for documentation of discussions with patients and those close to them. There is also a reminder on the duty to consult.

With thanks to key contributors to this policy:

- Dr Paul Buss, Aneurin Bevan University Local Health Board
- Dr Idris Baker, Consultant Palliative Care Medicine, Swansea Bay University Local Health Board
- All Wales DNACPR Implementation Group members
- Patient/carer representatives including Mr Alan Buckle, Mr Keith Cass, OBE, Lesley Radley, Eric Burke, Jason Tugwell and Kat Shelley.
- Prof. Mark Taubert from 2020, in his role as chair of Advance & Future Care Planning Group Wales, who took on the role from the All-Wales DNACPR Implementation Group chaired by Paul Buss
- All Wales Advance & Future Care Planning Group members
- Health Inspectorate Wales and Care Inspectorate Wales who form part of the AFCP Group
- We have also met the Bereaved Families for Justice Cymru Group and heard their experiences of what happened during the Covid-19 pandemic. We are very grateful for their input and insights, which they shared generously despite the significant trauma experienced during this time.

Poem- The person on the bed

By Jeena R. Papaadi. A poem about her mother's hospital stay.

Doctors, why are you in such a hurry?
Yes, I know your time is valuable;
You need to attend to everyone.
But, take a moment, take a breath,
Please don't run away...

The old woman on the bed
Is waving to you, to grab your attention
Her voice is low, she knows you won't hear
While you're talking about her condition
To your team and to everyone else,
Except to her.

Pull a chair and sit by her if you can,
Touch her hand, look at her - it'll only take a moment.
Ask her how she's doing today.
Pretend, if you must, to care about her answer.
This little act would brighten her day.

Look around at the family;
Talk to them just as you talk to your team.
Include them, please. Make them feel they're important.
Because they are.

Tell them what you have instructed your team to do:
Let's try this, let's give this medicine
Let's do this test
Let's see if her condition improves.

So that when the nurse comes
In the middle of the night to give an injection,
The family isn't startled; they don't ask strange questions.
They trust, if they are already told. It's as simple as that.

And when you realise the patient is passing
Or will pass away soon,
Don't be afraid to look the family in the eye:
You see, more often than not, they know it too.

They want to hear it from you.
Don't whisper among yourselves, young doctors,
Don't exit the room quickly, awkwardly,
Please don't run away.

The family knows it's tough on you, too.
But they need you at this moment.
Give them that one moment.
Be vulnerable, it's okay.
It's okay.

Just stay a moment. Be awkward.

You don't need to don a mask
At all times.
Allow it to shed, sometimes.
They know you're human too.
The one thing that scares everyone
Is indifference.

Allow them to see
Your vulnerability. Your humanness.
Because it would matter to them.
A fleeting moment to you, perhaps,
A lifetime memory, to them.

Yes, that one moment you give
Would make a world of difference
To the family members
Of the person on the bed.

Jeena R. Papaadi