

**East Midlands Ambulance Service NHS Trust**

**Resuscitation Decisions in End of Life Care Standard  
Operating Procedure**

**Links**

The following documents are closely associated with this policy:

- End of Life Care Policy
- Clinical Management in End of Life Care Standard Operating Procedure
- Untoward Incidents Reporting Policy
- Medical First Responders SOP

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# Resuscitation Decisions in End of Life Care Standard Operating Procedure

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## 1. Introduction

- 1.1. East Midlands Ambulance Service NHS Trust is committed to providing high quality, safe and effective care to individuals approaching the end of their life.
- 1.2. The Trust recognizes that a patient approaching the end of life should be managed with dignity and with their wishes adhered to wherever possible.

## 2. Objectives

- 2.1. The objectives of this procedure are to:
  - Ensure that all patients with identified end of life needs receive safe and effective care in the most appropriate place, including preferred place of death where appropriate.
  - Ensure that all patients approaching the end of life receive care within a legal framework and that staff are empowered to achieve this with confidence.

## 3. Scope

- 3.1. This procedural document applies to all pre-hospital practitioners attending a patient with end of life needs. It also applies to all staff working within the Emergency Operations Centres, Community First Responder Schemes and by all Voluntary Aid Societies and Private Providers deployed by East Midlands Ambulance NHS Trust dependent upon scope of practice.

## 4. Definitions

- 4.1. **End of Life:** People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:
  - advanced, progressive, incurable conditions
  - general frailty and coexisting conditions that mean they are expected to die within 12 months
  - existing conditions if they are at risk of dying from a sudden acute crisis in their condition
  - life-threatening acute conditions caused by sudden catastrophic events.
- 4.2. **DNA-CPR: Do Not Attempt Cardiopulmonary Resuscitation:** a document that provides evidence that a patient should not receive CPR in the event of cardiac arrest (unless from an unrelated reversible cause for example choking).
- 4.3. **Advanced Care Planning:** A voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse treatment in specific circumstances.

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- 4.4. **Lasting Power of Attorney:** A Lasting Power of Attorney (LPA) is a legal document which allows someone to nominate another person (or persons) to make decisions on their behalf after they lose mental capacity to make their own decisions.
- 4.5. **Advanced Decision to Refuse Treatment:** A legally binding decision to refuse specific treatment made in advanced by a person who has capacity to do so. This decision only applies at a time when that person lacks capacity to consent to, or refuse a treatment. If this involves refusal of life sustaining treatment it must be in writing, signed and witnessed and include the statement “even if life is at risk”.

## 5. Responsibilities

### 5.1. **The Medical Director** is responsible for ensuring:

- This procedure is monitored and reviewed in line with current clinical guidance on an annual basis.
- That related Clinical Key Performance Indicators and subsequent action plans are regularly reviewed by the clinical team in collaboration with the Divisions.
- Advice is provided to the Director of Human Resources and Organisational Learning on the requirements of training for all staff.
- Advice is provided to the Locality Management teams on the requirements for equipment

### 5.2. **Consultant Paramedics** are responsible for ensuring:

- That the procedure is current best practice and is updated as required and in the event of changes to best practice or identified risk.
- That advice is provided to all relevant roles within the trust and partner organisations.

### 5.3. **Locality Managers and Locality Quality Managers** are responsible for ensuring:

- Staff within their area of responsibility attend training on end of life care in line with the approved Education Training plan.
- Key performance Indicators are monitored and subsequent action plans are developed.
- Action plans are implemented, actions are completed and reports on progress and outcome are produced for the relevant committee.

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5.4. **Director of Workforce** is responsible for:

- The provision of suitable end of life education and training for all staff as per the Trust's training needs analysis.
- The production of regular reports on training to include both attendance and non attendance in relation to end of life care elements.

5.5. **Operational Staff** are responsible for:

- Adherence to this procedure
- Raising concerns as per Trust Incident reporting procedure

## 6. Clinical Significance

6.1. Although every individual may have a different idea about what would, for them, constitute a 'good death', for many this would involve:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends

6.2. A significant element within this is for the individual to die at their preferred place of death with dignity and respect.

## 7. Identification of End of life Patients

7.1. **DNA-CPR** is a document that provides evidence that a patient should not receive CPR in the event of cardiac arrest (unless from an unrelated reversible cause for example choking).

- The presence of such documentation provides evidence that active treatment should not be provided in the event of cardiac arrest.
- **DNA-CPR key principles are shown in appendix 1.**
- The East Midlands Unified DNACPR form **Appendix 3**, is recognised across the East Midlands – however other forms may also be used and should be accepted.

7.2. **In the event that a DNA-CPR is not available** it is NOT always mandatory for CPR to be performed. Consideration must be evident regarding the presence of a terminal illness and other forms of evidence surrounding resuscitation that suggest that CPR would not be in the patients' best interests (JRCALC/AACE 2013). **Please refer to appendix 4 resuscitation decisions procedure.**

7.3. **Advanced Decision to Refuse Treatment** enables a person to refuse specified medical treatment in advance of a time where they may be unable to

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consent or refuse treatment following the loss of mental capacity. **Please refer to appendix 2 Advanced Decision to Refuse Treatment and appendix 4 resuscitations decisions procedure.**

## 8. Resuscitation Decisions in End of Life Care

- 8.1. Please refer to appendix 4 – Resuscitations Decisions Procedure
- 8.2. In all cases of end of life care it is essential to communicate clearly with carers and relatives and provide support for all present.
- 8.3. In the event that a patient suffers a cardiac arrest **CPR should not** be commenced in the event that:
- The cardiac arrest is NOT caused by an unrelated and reversible cause (i.e. choking or opiate overdose)

**AND**

- The patient would not normally be resuscitated under the ROLE guidance

**OR**

- The patient has a valid DNACPR or advance directive to refuse treatment or you have a verbal instruction from a healthcare professional to that effect. **(Please refer to appendix 1 for further guidance)**

**OR**

- There is evidence that the patient is expected to die within hours or days due to a terminal illness (even in the absence of a DNACPR form).

## 9. Consultation

- 9.1. These guidelines have been developed in conjunction with the East Midlands Clinical Advisory Group for End of life which includes representation from across the East Midlands.

## 10. References/Bibliography

- Leadership Alliance for the Care of Dying People (2014) One chance to get it right. HMSO, London.
- Department of Health (2008) End of Life Strategy
- Joint Royal Colleges Ambulance Liaison Committee (2013) UK Ambulance Service Clinical Practice Guidelines
- National End of Life Care Programme (2012) Capacity, care planning and advance care planning in life limiting illness. NHS EOLCP, London.
- British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (2014) Decisions Relating to Cardiopulmonary Resuscitation 3rd ed.

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## 11. Monitoring Compliance and Effectiveness

This policy will be reviewed through the Clinical Effectiveness Group through reporting on local and regional incidents and feedback.

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## Appendix 1: DNA-CPR key Principles

### Key Messages:

A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not to attempt CPR rests with the healthcare professionals responsible for the patient's immediate care.

Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

From "Decisions Relating to Cardiopulmonary Resuscitation 3<sup>rd</sup> ed." British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (2014).

### How should a DNA-CPR directive be recorded?

There is no standard DNA-CPR form. Many Trusts will record the directive on a form specific for that purpose. However, a resuscitation directive can still be documented on a letter or as an entry in the patient notes.

### Do I need to see a DNA-CPR for it to be valid?

Staff should be certain beyond reasonable doubt that a DNA-CPR exists, but this does not necessarily mean that staff must see the physical DNA-CPR.

Where a crew have been notified by EOC and/ or the Clinical Assessment Team that a DNA-CPR exists it is not necessary for the crew have sight of the physical document.

If clinical staff are informed by a registered health care professional that a DNA-CPR exists, it is reasonable to record the professional's name and honour the directive.

Staff should seek evidence that a DNA-CPR exists when unsubstantiated statements regarding DNA-CPR are made by the patient's relatives or carers. Staff should attempt to make contact with the patient's health care team seek confirmation. If it is not possible, staff should contact the Clinical Assessment Team for guidance.

### How do I ensure a DNA-CPR is valid?

If staff are presented with a DNA-CPR it is reasonable to check that the DNA-CPR: is for the correct patient, and should be signed by the clinician making the DNA-CPR.

### Should a DNA-CPR have a review date?

Many DNA-CPR forms will not have a review date. This is acceptable and indicates that the patient's condition is not expected to improve.

**Can a DNA-CPR also apply to a child?**

Yes. Often these will be in the form of a letter from the lead clinician setting down a detailed resuscitation care plan. The parents have usually been involved in this care. In some circumstances the plan may advise that a limited resuscitation takes place (e.g. bag and mask and chest compression only). Where at all possible a Patient Specific Protocol will be created.

**Should we still resuscitate a patient who is clearly in the terminal phase of an illness, but there is no DNA-CPR?**

Under the AACE UK Ambulance Services Clinical Practice Guidelines (2013) Recognition of Life Extinct (ROLE) procedures, resuscitation should be discontinued in patients in “the final stages of terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR directive has been made.” There should be clear evidence of terminal illness and this should be detailed on the PRF. Terminal illness does not just include advanced malignancy, but includes conditions such as end stage cardiac and respiratory illnesses.

Examples of such evidence include: Terminal illness documented in the patient’s District Nursing notes. Terminal illness documented in patient-held palliative care.

Evidence of injectable palliative care such as:

- o opioid analgesia
- o anxiolytics e.g. midazolam, haloperidol
- o anti-secretion medications e.g. glycopyrronium, hyoscine butylbromide

**Are there circumstances where a patient who has a DNA-CPR should still be resuscitated?**

Occasionally a patient who has a DNA-CPR may suffer from a cardiac arrest from a clearly reversible cause such as opioid toxicity or choking. In these very rare occasions resuscitation should be considered as it is not within the foreseeable considerations of the DNACPR.

**Should a patient with a DNA-CPR still be treated for other conditions?**

Yes. A DNA-CPR purely relates to CPR and the patient should still receive treatment for any other condition. Therefore, it would be reasonable to discuss the most appropriate treatment with the patient and their medical team/ GP, these wishes may also be included within a care plan. It is important that conveyance to the Emergency Department is not the primary choice unless indicated.

**Does the patient, or their relatives, need to agree a DNA-CPR?**

Although there is no legal requirement for patients to consent to a DNA-CPR, usually where a patient has capacity they will be involved in the directive. Some patients may indicate that they do not wish to discuss resuscitation and in these cases the patient may not be aware of the DNA-CPR.

The only circumstances when a relative (or other adult who is not the patient) must be consulted in clinical directives is where a person has appointed a proxy with Lasting Power of Attorney (Health & Welfare) and subsequently lost their capacity to make their own directives. The extent of their directive-making capabilities depends on the scope stipulated in the LPA.

**What is the difference between a DNA-CPR and an Advanced Decision to Refuse Treatment?**

A DNA-CPR is simply a method of documenting the resuscitation component of a care plan and is a clinically led directive.

An Advanced Decision to Refuse Treatment is set out in law under the Mental Capacity Act 2005, which allows an individual to make directives regarding their care and treatment should they subsequently lose capacity. An ADRT can be about any component of a patient's treatment, not necessarily just resuscitation. Where an ADRT is for life-sustaining treatment the law requires that it is made in writing, signed and dated, and witnessed and should include the term "even if life is at risk".

## Appendix 2 – Advanced Decision to Refuse Treatment

### What is an ADRT?

An ADRT enables a person to refuse specified medical treatment in advance of a time where they may be unable to consent or refuse treatment following the loss of mental capacity. It is not possible to make an advance *request* for treatment; however such information can be used to inform consideration of the patient's best interests.

### Who can make an ADRT?

A person may make an ADRT if they:

- Are over 18 years old and,
- Have capacity at the time of making the ADRT.

### Do you have to have an End of Life Care (EoLC) diagnosis to make an ADRT?

ADRT's are not exclusive to End of Life Care, however are commonly seen in these scenarios. In EoLC situations ADRT's are often created to deal with resuscitation directives and it is essential to ensure that ADRT's which relate to life-sustaining treatment fulfil the legal requirement stipulated by the Mental Capacity Act 2005. It is reasonable to commence resuscitation whilst the facts of an Advance Directive are established.

### Can an ADRT be made verbally?

Only where the treatment being refused does not constitute a life-sustaining treatment.

### What if the ADRT is for Life-Sustaining Treatment?

The Mental Capacity Act 2005 stipulates that for an Advance Directive to be applicable for life-sustaining treatment it **must** meet the following criteria:

- a) It must be in writing.
- b) Where an ADRT is for life-sustaining treatment the law requires that it is made in writing, signed and dated, and witnessed and should include the term "even if life is at risk".
- c) It must specify the treatment being refused; this can be written in layman's terms.
- d) It must be signed by the patient or another in their presence if they are unable to sign it themselves.
- e) It must be witnessed.

It has been established in case law that these criteria **must be met in full** for the Advance Directive/ADRT to be valid in law<sup>1</sup>.

<sup>1</sup> See *An NHS v D* [2012] EWHC 885 (COP)

**When is an ADRT *not* valid?**

An ADRT is not valid if the patient:

- a) Has withdrawn the directive at a time when s/ he has capacity to do so;
- b) Has, under a Lasting Power of Attorney created **after** the ADRT was made, conferred the authority to a donee (or donees) to give or refuse consent to the treatment to which the ADRT relates, or
- c) Has done anything else clearly inconsistent with the advance directive remaining his/ her fixed directive.

**The patient has a DNA-CPR directive, but doesn't have an ADRT. Does that mean the patient has not been consulted?**

Not necessarily. A DNA-CPR directive is a treatment directive taken in advance by a clinician. An ADRT is a refusal of treatment made in advance by the patient. The creation of an ADRT may be made for many personal reasons. ADRT's, where valid and applicable, like contemporaneous refusals of treatment should be respected regardless of whether the clinician understands or agrees with the patient's directive or their rationale.

**What is the relationship between ADRT's and Lasting Power of Attorney?**

If an ADRT is made, and subsequently the patient confers the authority to make the refusal specified in the ADRT to a donee under the Lasting Power of Attorney - Health and Welfare (LPA) the ADRT is no longer valid. Here, the LPA supersedes the Advance Directive. However, if the patient creates and registers a donee under Lasting Powers of Attorney, and subsequently makes an Advance Directive then the Advance Directive is valid. Essentially, the more contemporary of the two tools should be used. It is important to remember that Advance Directives are only applicable for the treatment specified.

**When is an ADRT *not* applicable?**

An ADRT is not applicable to the treatment in question if:

- a) At the material time the patient has capacity to give or refuse consent to it;
- b) The treatment is not the treatment specified
- c) Any circumstances specified are absent, or
- d) There are reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of the ADRT and which would have affected his directive had s/ he anticipated them.

If there is any uncertainty about the validity or applicability of an ADRT then clinical advice should be sought. In some cases, the Court of Protection will be required to intervene. Whilst advice is being sought, nothing in the ADRT should prevent the provision of life-sustaining treatment or treatment to prevent deterioration.

An invalid ADRT may still provide information which enables clinicians to assess a person's best interests if they have reasonable grounds to think it is a true expression of the person's wishes. In such circumstances, staff on scene should follow National Clinical Guidelines and seek clinical support.

## Appendix 3: Regional Unified DNACPR Form

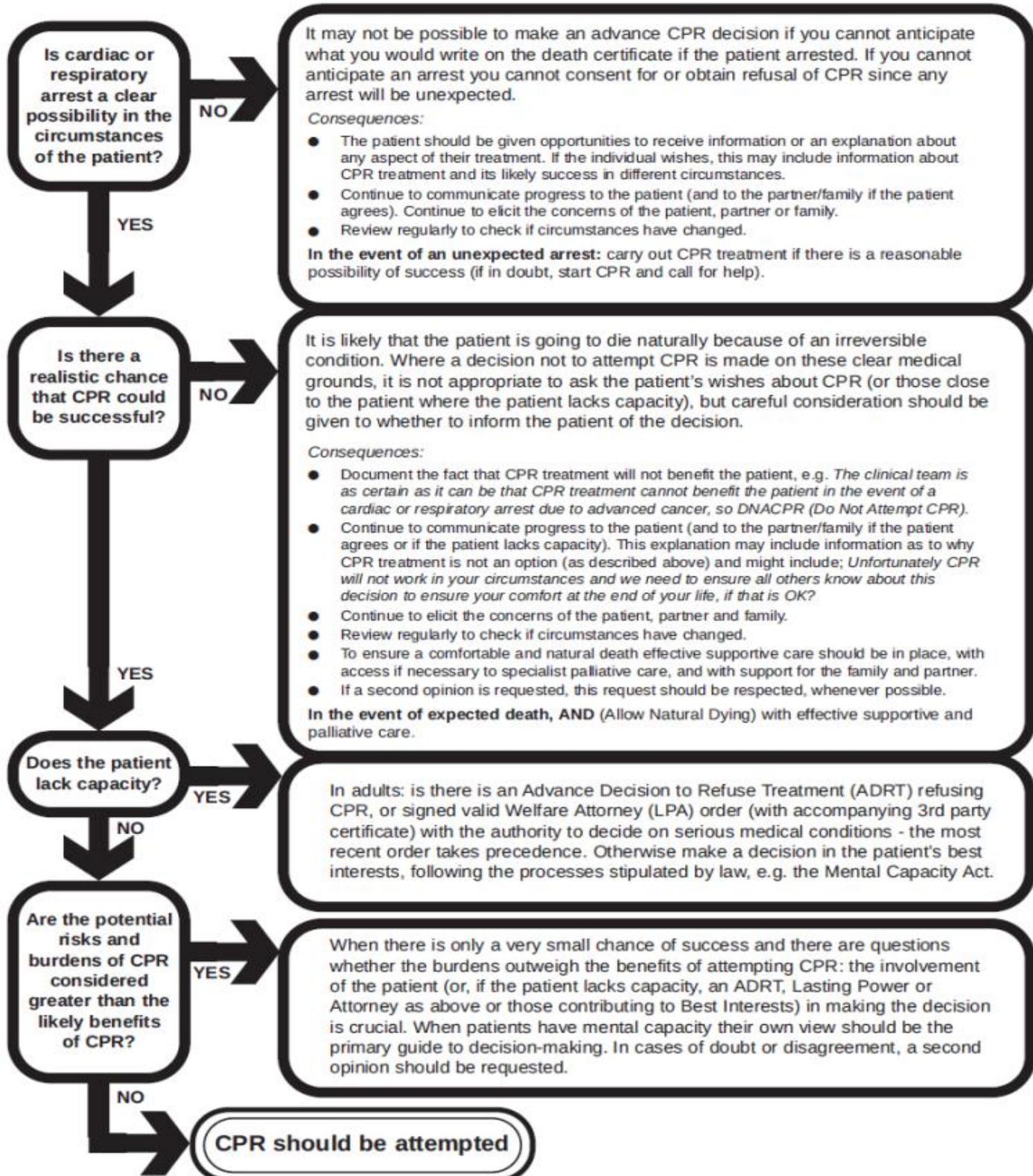
| <b>DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)</b>   |                            |  |  |                               |                     |
|--|----------------------------|--|--|-------------------------------|---------------------|
| This document applies to CPR decisions exclusively and must be used in accordance with local resuscitation policy<br>The person must be appropriately assessed to ensure they receive all other appropriate care.<br>Form developed by the NHS in the East Midlands.   |                            |  |  |                               |                     |
| <b>Section 1: DNACPR Category. Delete A or B to identify which applies</b><br><b>A. For a person at the end of life. DNACPR applies across all care settings. No review necessary.</b>   |                            |  | Addressograph Label<br>Patient name: _____<br>Address: _____<br>Date of birth: _____<br>NHS No: _____<br>Telephone No: _____ |                               |                     |
| OR<br><b>B. DNACPR decision for periodic review during admission/change in place of care or on discharge. State the first review date in section 5. (Should option A then become applicable a new form must be completed)</b><br><b>ORIGINATED BY (Optional):</b><br>e.g. Doctor in training (PRINT) _____ Signature _____<br>GMC No _____ Date _____<br><b>ORIGINATED BY AND/OR ENDORSED BY (Obligatory):</b><br>Responsible clinician/nurse (PRINT) _____ Signature _____<br>Designation _____ Date _____ Organisation _____<br>If applicable GMC No _____   |                            |  | <b>Location of patient when DNACPR form completed</b><br>_____   |                               |                     |
| <b>Section 2: Reason for DNACPR (please tick those that apply):</b><br><br>Patient's condition indicates that CPR is unlikely to be successful because _____ <input type="checkbox"/><br>_____<br><br>CPR is not in accord with a valid Advance Decision to Refuse Treatment <input type="checkbox"/><br><br>Patient does not consent to CPR <input type="checkbox"/>  |                            | <b>Section 3: Communication with patient and carer/relevant others (Tick all that apply):</b><br>It is good practice to explain why CPR will not be attempted, <i>unless doing so would cause unnecessary distress.</i><br><br>This <b>has</b> been discussed with the patient <input type="checkbox"/><br>This <b>has</b> been discussed with _____ (name) on date _____ Relationship to patient _____ contact details _____ <input type="checkbox"/><br><br>This <b>has not</b> been discussed with the patient because it would cause unnecessary distress or they lack capacity (delete as applicable) <input type="checkbox"/><br>This <b>has not</b> been discussed with any relevant other e.g. family/carer because _____ <input type="checkbox"/><br><br>Fully record details of all CPR discussions in the patient's notes |  |                               |                     |
| <b>Section 4: Complete section below only for patients who lack capacity</b><br>Does the patient have a legally appointed and registered welfare attorney? <span style="float: right;">Yes No</span><br>Have they been consulted and discussion documented? (if yes to question above) <span style="float: right;">Yes No</span><br>If no attorney or others to contribute to Best Interests decision, has an IMCA been contacted? <span style="float: right;">Yes No</span><br>Confirm that decision made following the best interest process of Mental Capacity Act <span style="float: right;">Yes No</span><br><br>Fully record details in the patient's notes   |                            |  |  |                               |                     |
| <b>Section 5: DNACPR review. Please complete if indicated by B in section 1 on the date stated below</b>   |                            |  |  |                               |                     |
| Date of review   | Reviewer's name (capitals) | Reviewer's signature   | Next review due  | Designation & contact details | Location of patient |
|  |                            |  |  |                               |                     |
|  |                            |  |  |                               |                     |
|  |                            |  |  |                               |                     |
| <b>Section 6: IF DNACPR CANCELLED – CLEARLY CROSS THROUGH DOCUMENT WITH 2 LINES NAME, DATE AND SIGN with a reason for cancellation</b>   |                            |  |  |                               |                     |
| <b>Section 7: Organisational communication</b><br><b>The clinical team must ensure the DNACPR paperwork accompanies the patient on transfers and that professional colleagues receiving the patient are aware of the decision</b><br><br>Patient's GP _____ Telephone No _____ Professional contact out of hours Name _____<br>Address _____ Telephone No _____ Address _____<br><br>Has person in charge of patient's daily care (e.g. GP, Community Nurse or Care Home) been informed <span style="float: right;">Yes No</span><br><br>A copy should be kept in the notes exclusively for audit purposes and marked as COPY.<br><br><b>When at home or place of care/residence</b> ensure the original form is accessible to visiting health or social care professionals. E.g. place the form at front of community notes or message in a bottle. Ensure it is ready should an emergency/urgent call be made<br><br>Does the patient have a preferred place of care at the end of life? <span style="float: right;">Yes No</span><br><br>If yes, where? Tick Box - Home <input type="checkbox"/> Hospital <input type="checkbox"/> Care Home <input type="checkbox"/> Hospice <input type="checkbox"/> Other (please state) _____ |                            |  |  |                               |                     |

**MAKING A DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) DECISION FRAMEWORK**



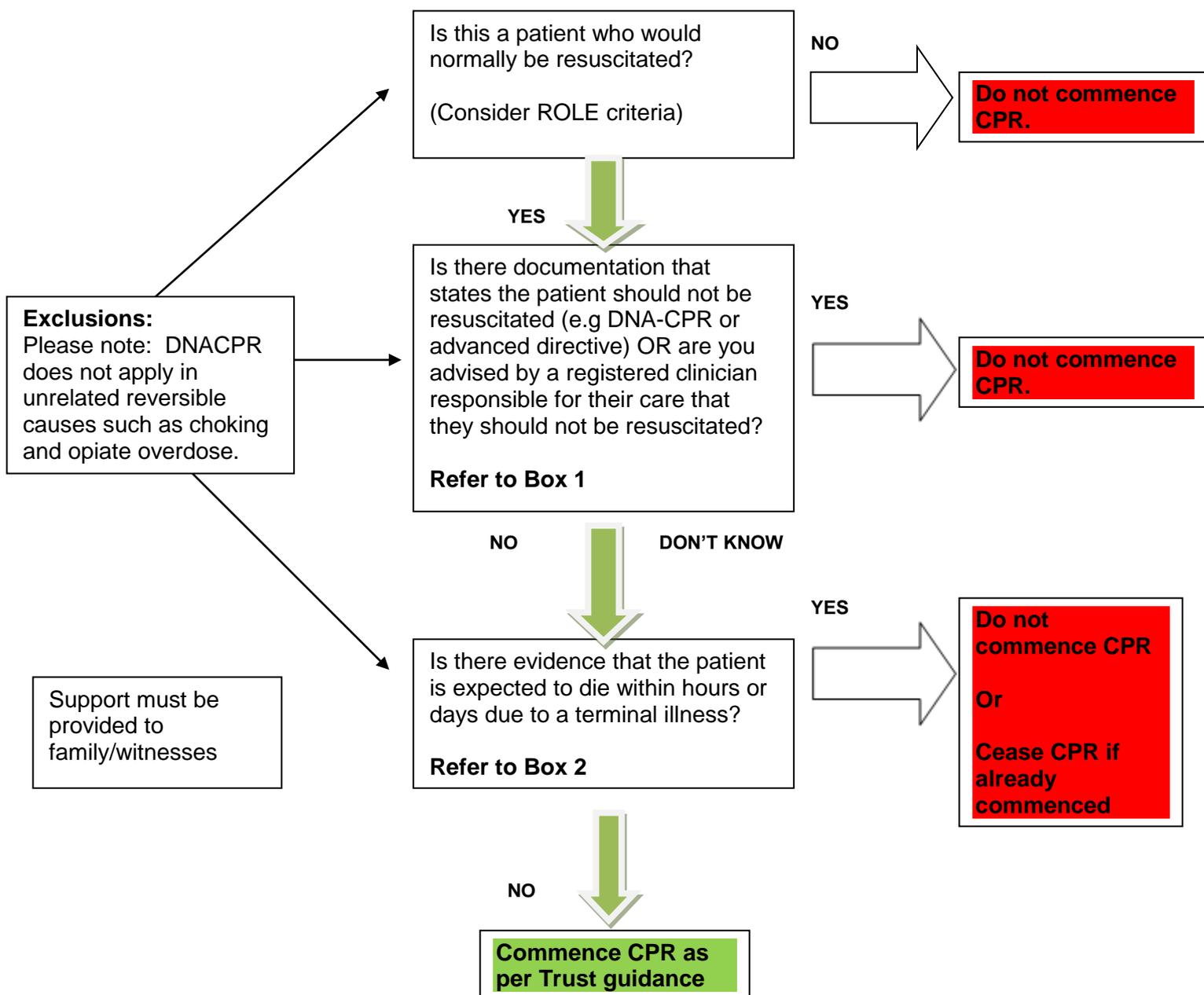
**Healthcare Professional Completing This DNACPR Form**

This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available. Whether in the acute hospitals or the community setting, this will be a senior experienced, doctor or nurse, who has undertaken appropriate training and education in communication and resuscitation decision making, according to the requirements of their employer. This decision should be shared with the Multi-disciplinary Team at the next opportunity.



v49 Adapted from: 2007 BMA/RC/RCN Joint Statement on CPR; Regnard C & Randall F. Clinical Medicine, 2005; 5: 354-60; and A Guide to Symptom Relief in Palliative Care, 6th ed Radcliffe medical Press, 2010.

## Appendix 4: Resuscitation Decisions Procedure



### Box 1

**Note: DNA-CPR orders can be:**

- On plain paper and do not have to be on a standard form
- Can be signed by any registered clinician (i.e. Doctor or Nurse)
- Can be given verbally / verbally confirmed**
- Do not have an expiry UNLESS stated
- Can be in the form of an advanced directive to refuse treatment signed by the patient.
- Must be accepted unless you have reason to believe it is not genuine.
- **A photocopy is acceptable as long as there is no evidence that it should not be considered valid.**

### Box 2

Look for information to determine if the patient is at the end of life.

- District Nursing notes indicating terminal phase of disease.
- If possible contact responsible clinician to confirm.
- JRCALC/AACE 2013 guidance.