October 2014 3rd edition

Decisions relating to cardiopulmonary resuscitation

Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing

(previously known as the "Joint Statement")

BMA

Resuscitation Council (UK)

Royal College of Nursing

Contents

Preface

Background to decisions about cardiopulmonary resuscitation

Cardiopulmonary resuscitation (CPR) was introduced in the 1960s as a treatment that for some people may re-start their heart when they suffer a sudden cardiac arrest due to a heart rhythm disturbance, most commonly triggered by acute myocardial infarction ('heart attack') from which they would otherwise have been expected to make a good recovery. The context of sudden cardiac arrest in a person with a heart condition remains the situation in which CPR is most likely to be successful. The probability of success in any individual is influenced by other factors and in many people with advanced chronic disease the likelihood of CPR being successful is relatively low (see section 1). CPR involves chest compressions, delivery of high-voltage electric shocks across the chest, attempts to ventilate the lungs and injection of drugs.

The cessation of the heartbeat and/or of breathing is an integral part of the natural process of dying from any cause. As awareness of CPR increased and resuscitation equipment became more widely available and more portable, attempts at CPR became more common in situations other than a sudden cardiac arrest due to a heart attack. These included circumstances in which people were gravely ill, and in which attempts to re-start their heart either would not work, subjecting them to violent physical treatment at the end of their life and depriving them of a dignified death, or might restore their heart function for a brief period and possibly subject them to a further period of suffering from their underlying terminal illness. It was therefore recognised that, whilst there were some circumstances in which CPR could restore a person to a period of what the person considers a worthwhile life, there were other circumstances where attempting to prevent a natural and inevitable death could do harm. Anticipatory decisions about CPR were recognised as the way to try to ensure that dying people were not subjected to the trauma and indignity of attempted CPR with no realistic prospect of benefit.

Methods of recording or communicating Do Not Attempt CPR (DNACPR) decisions were initially varied, inconsistent and unreliable. Standardised forms on which to record DNACPR decisions were introduced to provide a readily accessible means of documenting and communicating such anticipatory decisions to those faced with having to make an instantaneous decision about whether or not to start CPR immediately when a person suffers cardiorespiratory arrest. The immediacy of response that is needed if CPR is appropriate and is to be successful is the driver for having a clear record of any anticipatory decision about withholding CPR. Most healthcare organisations have a policy that requires an initial presumption to attempt CPR in a person who dies or suffers sudden cardiac arrest in the absence of a valid, recorded anticipatory decision that CPR will not be attempted.

This guidance

Healthcare professionals are aware that decisions about whether or not CPR will be attempted raise very sensitive and potentially distressing issues for patients and those emotionally close to them. As a consequence there has been stand-alone professional guidance on CPR decision-making since the 1990s and guidance published jointly by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing since 2001 (sometimes referred to as the 'Joint Statement').

In 2014 a judgment by the Court of Appeal stated:

"The problems generated by decisions whether or not to impose [Do–not-attempt-CPR] 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..."[1]

The previous edition of this guidance was published in 2007 following extensive consultation with key stakeholders including professional bodies, patient groups, regulators and charities. The guidance was revised in 2007 in order to ensure compliance with the Mental Capacity Act 2005, to respond to feedback on practical aspects of implementing the 2001 guidance and to recognise the increasing importance of multidisciplinary working (for example by acknowledging the role of suitably experienced nurses in the CPR decision-making process in some nurse-led settings). These changes reflected emerging developments in healthcare professionals' roles and the way health care is delivered today.

The high-level ethical principles that were embedded in the 2007 edition underpin the guidance in this third edition. This revision of the guidance places even greater emphasis on ensuring high-quality communication and

recording of CPR decisions. This is in response to public and professional debate about CPR decisions, and to feedback from individual healthcare professionals and professional bodies. We hope that these changes will help to support all healthcare professionals in their day-to-day consideration of decisions about CPR.

Some healthcare professionals do not find it easy to discuss CPR with their patients, but this must not prevent discussion, to involve patients in shared decision-making whenever appropriate, or in some circumstances to inform patients of a decision and explain the reasons for it. There must be a presumption in favour of such patient involvement. Discussion about dying and about CPR must not be avoided to try to spare the patient distress unless there is good reason to believe that such distress will cause them harm.

The guidance identifies the key ethical and legal principles that should inform all CPR decisions. The high-level ethical principles are the same for all people, in all settings, but differences in clinical and personal circumstances make it essential that all CPR decisions are made on an individual basis. How these individual decisions are made is also guided by the law, which differs between adults and children and differs in England and Wales, in Scotland and in Northern Ireland. For example, a central tenet of the mental capacity legislation in England and Wales is 'best interests' and in Scotland it is 'benefit'. These terms can be interpreted in largely the same way and so, for the purposes of this guidance, are used interchangeably in parts of the guidance. This guidance provides a framework to support decisions relating to CPR and effective communication of those decisions. It also highlights relevant legal requirements and differences.

This guidance does not address all the complex clinical considerations that healthcare teams can face. It provides general principles that allow local CPR policies to be tailored to local circumstances. Local and regional policies may also contain more detailed guidance than can be provided here; they may include, for example, specific information about the allocation of individual responsibilities.

Professional bodies such as nursing and medical organisations will be able to advise on the application of a CPR policy to specific specialities and areas of practice. Details of additional published guidance are given at the end of this document and, where appropriate, sources of more detailed information are signposted in the guidance itself.

This guidance will be reviewed jointly by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing as policy and legislation develops and/or in the light of evolving changes in clinical practice. The most up-to-date version of this guidance will be available on the organisations' websites, listed below.

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Main messages

All establishments that face decisions about attempting cardiopulmonary resuscitation (CPR), including hospitals, general practices, care homes, hospices and ambulance services, should have a policy about CPR decisions. These policies must be readily available and understood by all relevant staff and should also be available to the public.[2,3,4]

The main messages below are not designed to be read in isolation from the rest of the document. Given the very serious nature of the decisions being made, readers are urged to take the time to consider the whole document. These 'messages' are intended as an aide-mémoire to highlight some of the main points arising from the guidance.

1. Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

2. If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.

3. For many people anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

4. Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

5. Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.

6. Triggers for review should include any request from the patient or those close to them, any substantial change in the patient's clinical condition or prognosis and transfer of the patient to a different location (including transfer within a healthcare establishment).

7. For a person in whom CPR may be successful, when a decision about future CPR is being considered there should be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best-interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision-makers.

8. If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing treatment (ADRT), specifically refusing CPR, this must be respected.

9. If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.

10. Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or of those close to the patient. However there is a presumption in favour of informing a patient of such a decision. The patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.

11. Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved.

12. There should be clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them.

13. Any decision about CPR should be communicated clearly to all those involved in the patient's care.

14. It is essential that healthcare professionals, patients and those close to patients understand that a decision not to attempt CPR applies only to CPR and not to any other element of care or treatment. A DNACPR

decision must not be allowed to compromise high-quality delivery of any other aspect of care.

15. A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include but are not restricted to: choking, a displaced tracheal tube or a blocked tracheostomy tube.

16. Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

17. Decisions about CPR must be free from any discrimination, for example in respect of a disability. A best-interests decision about CPR is unique to each person and is to be guided by the quality of future life that individual would regard as acceptable.

18. Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form.

19. 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.

20. Use of a CPR decision form that is used, recognised and accepted across geographical and organisational boundaries is a basic recommendation and may be paper-based or electronic, subject to local agreement.

21. Recorded decisions about CPR should accompany a patient when they move from one setting to another.

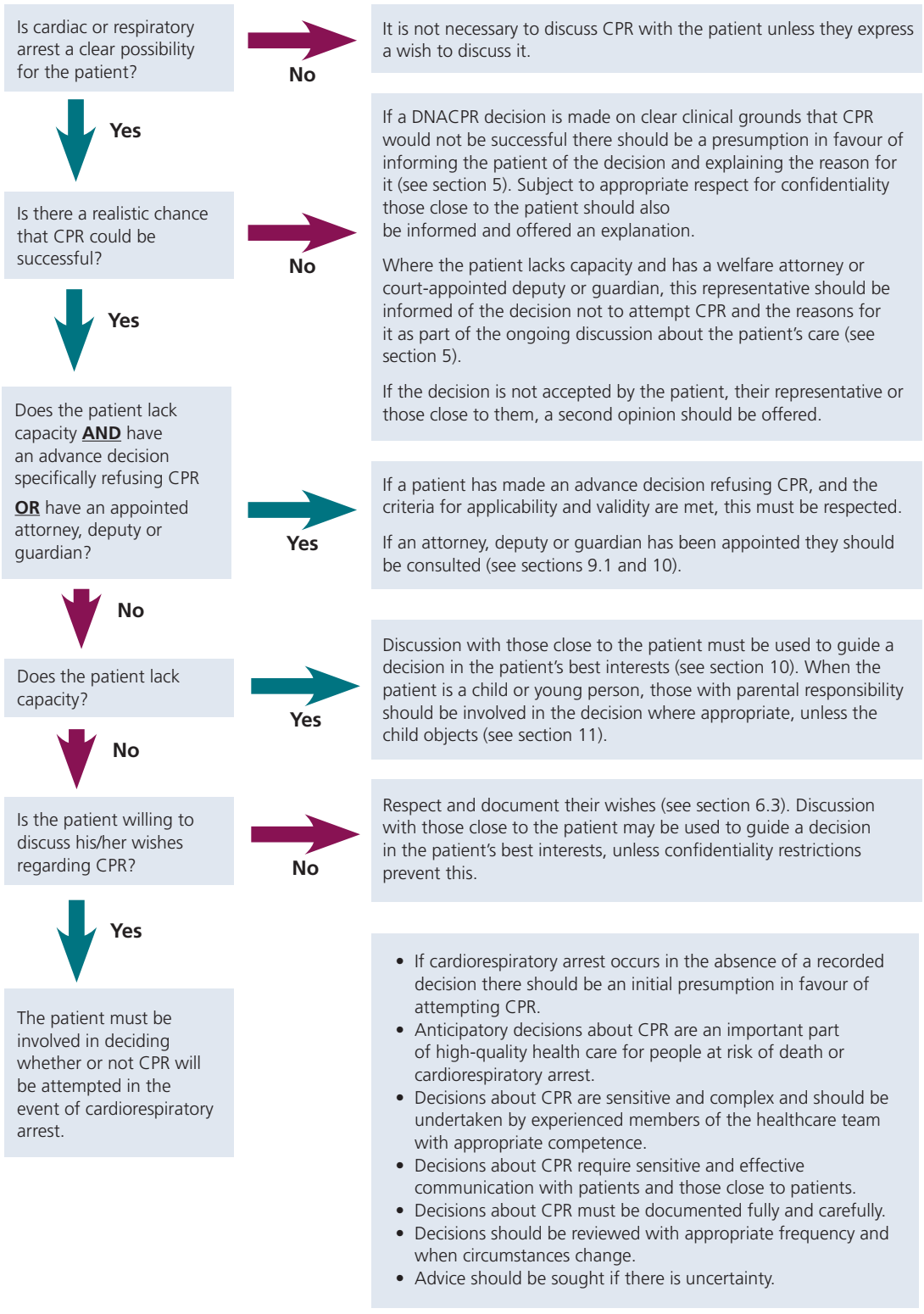
22. Records of decisions about CPR must be accurate and up-to-date. Systems (whether paper-based or electronic) for recording these decisions must be responsive and reliable, in particular, to any change in the decision about CPR.

23. 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.

24. Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

25. Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and, where appropriate, explained to the patient and those close to the patient at the earliest practicable opportunity.

Decision-making framework



1. Introduction

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

Prolonging a person's life usually provides a health benefit to that person. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or to the potential harms and burdens of treatment. The decision to use a treatment should be based on the balance of risks and benefits to the individual receiving the treatment. This principle applies to any treatment, including cardiopulmonary resuscitation (CPR).

CPR is undertaken in an attempt to restore spontaneous circulation and breathing in a person in cardiac and/or respiratory arrest. CPR is an invasive and traumatic medical intervention and usually includes chest compressions, attempted defibrillation, injection of drugs and ventilation of the lungs. In some cases spontaneous circulation may be restored by prompt defibrillation alone.

The proportion of people who survive cardiorespiratory arrest following CPR is relatively low. In hospital, the chance of surviving cardiorespiratory arrest to discharge varies considerably and depends on many factors, including co-morbidities and the cause and circumstances of the arrest. In most hospitals the average survival to discharge is in the range of 15-20%.[5,6,7,8]

Where cardiac arrest occurs out of hospital and resuscitation is attempted, the average survival rate is lower, usually 5-10%.[9,10,11] As with in-hospital arrest the probability of success depends on many factors including the cause of the arrest, how soon after the arrest CPR is started, and the subsequent availability of resuscitation equipment and trained personnel.

However, when considering these data it should be noted that these are average survival rates. People's individual circumstances should be taken into account when considering their chance of survival, which could range from zero to almost 100%, depending on the cause and circumstances of the arrest.

Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture. In many cases it may be followed by prolonged treatment in an intensive care unit (ICU), often including artificial ventilation.

In the immediate post-CPR period most people require at least a brief period of observation and treatment in an ICU or a coronary care unit.[12] Of those who need ICU care, most will require a period of artificial ventilation, and some will require renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an aortic balloon pump.

It is not uncommon also for difficult decisions about CPR to arise in people for whom there may be some chance of re-starting the heart after cardiac arrest but for whom admission to an ICU for continued artificial organ support would be clinically inappropriate because they would be unlikely to survive (see section 6).

There is also some risk that the person will be left with brain damage and resulting disability, especially if there is delay between cardiorespiratory arrest and the initiation of CPR. CPR attempts are unavoidably physical and potentially traumatic, as a result of which death may occur in a manner that neither the person affected nor people close to them would have wished. Detailed assessment is crucial to determine whether the benefit of attempting CPR outweighs the risks and burdens for each individual.

2. Advance care planning

For many people receiving care, in hospital or in the community, the likelihood of cardiorespiratory arrest is small and no clinical decision is made in advance of such an event. If cardiorespiratory arrest does occur unexpectedly, CPR will almost always be attempted, in accordance with the advice in this guidance, namely an initial presumption in favour of attempting CPR (see section 8). There is no ethical or legal requirement to initiate discussion about CPR with patients, or with those close to patients who lack capacity, if the risk of cardiorespiratory arrest is considered low.

In some cases there is an identifiable risk of cardiac or respiratory arrest, either because of an underlying incurable condition (such as cancer or advanced heart failure), because of the person's medical history (such as myocardial infarction or stroke), or current clinical condition (such

as overwhelming sepsis). If there is a risk of cardiac or respiratory arrest, it is important to make decisions about CPR in advance whenever possible. There should be a full clinical assessment of the chances of a successful outcome.

Healthcare professionals have an important role in helping people to participate in making appropriate plans for their future care in a sensitive but realistic manner, making clear whether or not attempted CPR could be successful. Helping people to have a better understanding of CPR in their situation, when appropriate, and to clarify their wishes in respect of CPR should be regarded as a marker of good practice in all healthcare settings. For example, for people who have a cardiovascular implanted electronic device (CIED), in particular an implanted cardioverter defibrillator (ICD), discussions about CPR towards the end of life should include discussion of possible deactivation of the shock function of their ICD. As they approach the end of life the benefit from the device attempting to prolong life may be outweighed by the burdens of repeated shocks from the ICD. Further guidance on the management of CIEDs in people towards the end of life is under development by the Resuscitation Council (UK), British Cardiovascular Society and National Council for Palliative Care.

Ensuring that timely discussion takes place about CPR – undertaken by healthcare professionals with the necessary training and expertise – and that a decision is made in advance is preferable to making decisions in a crisis situation, in which the patient's ability to contribute to the process may be reduced and which can be more stressful for those close to the patient and the staff involved. Advance care planning allows each individual to choose in advance what interventions, including CPR, they wish to receive in the event of deterioration in their health, whether that is due to progression of a known condition or to an unexpected secondary illness or injury.[13] The concept of treatment escalation planning is being used increasingly, particularly in hospitals, to plan and focus on what interventions a patient will or will not receive. Consideration of such choices as 'treatment options' can be perceived by patients and healthcare professionals as being a more positive approach than a predominant focus on decisions about which treatments to withhold, including DNACPR decisions.[14] For this reason terms such as 'ceilings of care' may be better avoided.

For many people with advanced or multiple medical conditions the optimal time to undertake advance care planning is when they are relatively stable, in their home or usual care environment where it can be supported by the healthcare professionals who know them well. These may include doctors and nurses based in general practice, in the community, in hospices and in hospitals. Making a decision in advance also ensures that there is time for all the appropriate people to be involved in any decision. It also allows time for reflection and scrutiny of any decision. Advance care planning should be subject to clinical audit.

Unfortunately, it is inevitable that there will be situations in which advance care planning has not taken place – for example when an unconscious or acutely ill person presents as an emergency. When such planning has not occurred and a crisis results in acute or emergency hospital admission, the need to support the patient in reaching a decision, or to make a swift decision in their best interests, is forced upon healthcare professionals. They may not have met the patient before and may have limited information about his or her clinical condition, personal circumstances, views and beliefs. Furthermore the patient may not be well enough to participate fully in a process of shared decision-making. These situations can present particular challenges for healthcare professionals making decisions about CPR.

Nevertheless it is crucial that an anticipatory decision about CPR is considered when a person is at risk of death or cardiorespiratory arrest. In a hospital setting, appropriate triggers to consider or review a decision about CPR include an unplanned or acute admission to hospital, improvement or deterioration in the person's clinical condition during hospital treatment (especially but not exclusively deterioration requiring review by an ICU outreach team), or transfer to a different clinical team or care environment (e.g. change of ward).

3. Non-discrimination

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all people with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the person's age, disability,[15] or on a professional's subjective view of a person's quality of life. Blanket policies that deny CPR or apply CPR to groups of people, for example to all patients in a hospice, nursing home or particular hospital ward, or to people above or below a certain age, are unethical and probably unlawful. Decisions or policies that discriminate in favour of, or against, people with defined disabilities would be unlawful under the Equality Act 2010 (in England, Wales and Scotland) or the Disability Discrimination Act (in Northern Ireland).

When assessing whether attempting CPR may benefit or be in the best interests of a person who lacks capacity, decision-makers must not be influenced by their own personal views about living with a particular condition or disability. The key issue is not the decision-maker's view of the quality of life following CPR, but an objective assessment of what is in the best interests of the patient. This must take account of all relevant factors, particularly the patient's own views about what would be an acceptable level of recovery, when this can be ascertained (see section 6).

4. Human Rights Act

Policies and individual decisions about CPR must comply with the Human Rights Act 1998. This Act incorporates the majority of rights set out in the European Convention on Human Rights into UK law. In order to meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempting CPR include the right to life (Article 2), the right to be free from inhuman or degrading treatment (Article 3), the right to respect for privacy and family life (Article 8),[16] the right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and the right to be free from discriminatory practice in respect of these rights (Article 14). The spirit of the Act, which aims to promote human dignity and transparent decision-making, is reflected in this guidance.[17]

In considering decisions about treatment in relation to the Act the courts have indicated that the degree of patient involvement required by Article 8 depends on the particular circumstances of the case and notably the nature of the decisions to be taken. An individual has to be involved in the decision-making process, seen as a whole, to a degree sufficient to provide her or him with the requisite protection of their interests.[18]

In 2014 the Court of Appeal concluded that when a decision about CPR is being considered "*there should be a presumption in favour of patient involvement and that there need to be convincing reasons not to involve the patient*"[19] and went on to say "*However, it is inappropriate (and therefore not a requirement of article 8) to involve the patient in the process if the clinician considers that to do so is likely to cause the person to suffer physical or psychological harm*".[20]

5. Decisions not to attempt CPR because it will not be successful

Adults with capacity may decide to refuse CPR (see section 9). Decisions about CPR may also be made following consideration of a balance of benefits and burdens (see section 6). In other cases, the decision not to attempt CPR is a straightforward clinical decision, if the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not re-start the heart and breathing for a sustained period. If there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. However, the person's individual circumstances, and the most up-to-date evidence and professional guidance must be considered carefully before such a decision is made. The ultimate responsibility for the decision rests with the most senior clinician responsible for the person's care, but discussion of the decision with agreement or consensus of the other members of the healthcare team is recommended whenever possible (see section 14).

Where people are known to have an advanced chronic illness, discussion and explanation about the realities of attempting CPR should be considered and, where appropriate, offered in advance of the last few weeks or days of life (see section 2). In the last few days of life, if this discussion has not taken place earlier, making and documenting a decision about CPR becomes increasingly important and urgent, but the patient's ability to engage in detailed discussions is often reduced by their declining health. When a person is in the final stages of an incurable illness and death is expected within a few hours or days, in almost all cases CPR will not be successful. CPR cannot reverse the person's underlying condition and it may prolong or increase suffering. In most cases it will be appropriate for a DNACPR decision to be made. However, 'blanket' policies are inappropriate. All decisions should be based upon the individual person's circumstances and wishes at the time. When it is clear that someone is dying from an advanced, irreversible condition, clinicians must be sensitive to the patient's emotional and physical condition and to fluctuations therein. It is not uncommon for difficult discussions between healthcare professionals and patients to cause some unavoidable distress. However, trying to explain a DNACPR decision to some patients for whom CPR will offer no benefit will impose an unnecessary burden by causing such distress that the dying person suffers harm, which may be physical or psychological.[21]

5.1 DNACPR applies *only* to CPR

A decision not to attempt CPR applies *only* to CPR.[22] All other appropriate treatment and care for that person should continue. It is important that this is widely understood by healthcare professionals and that it is made clear to patients and those close to them. This is essential as it is a common fear amongst members of the public that 'DNACPR' applies to all elements of treatment. Inclusion of decisions relating to CPR as part of an advance care plan or treatment escalation plan may help to emphasise which other treatment options are and are not appropriate for each individual, but quality of care should not be limited by any such plans or decisions. Healthcare professionals should ensure that a DNACPR decision is not allowed to compromise the quality of care for any patient. To avoid confusion, the phrase 'do not attempt cardiopulmonary resuscitation' should be used, rather than 'do not resuscitate' or 'do not attempt resuscitation'.

5.2 DNACPR decisions where CPR will not be successful and patients have capacity

In relation to decisions about CPR the courts have stated that there should be a presumption in favour of patient involvement and that there need to be convincing reasons not to involve the patient.

In a judgment in the Court of Appeal the Master of the Rolls stated:

"In my view, doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardio-respiratory arrest. If however 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. I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find that such decisions, if conscientiously taken, violate a patient's rights under article 8 of the Convention."[23]

Whilst there should be a presumption in favour of informing patients of DNACPR decisions (made because CPR will not be successful) some people make it clear that they do not wish to talk about dying or to discuss their end-of-life care, including decisions relating to CPR. When such wishes are expressed they should be respected. It is poor practice to force discussions on patients who have stated clearly that they do not want them. Any such refusal should be documented clearly, together with a plan to ensure that optimal care of the patient is not compromised by that refusal.

In all other circumstances, when a clinical decision is made that CPR should not be attempted, because it will not be successful, careful consideration must be given as to whether or not to inform the patient. Although people should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases people should be informed, but for some, for example those who know that they are close to the end of their life, such information may be so distressing as to cause the person to suffer physical or psychological harm.

These decisions become even more challenging in the context of a severe, acute illness (or acute deterioration in a chronic condition), when the person affected has not considered or recorded their wishes regarding end-of-life care. Whilst the presumption in favour of patient involvement remains, there will be circumstances when giving information and explanations about CPR decisions at an early stage to a person who is seriously ill may cause harm. However, failure to make a timely DNACPR decision when CPR will not be successful will result in people receiving inappropriate CPR that they would not have wanted. Faced with such a situation clinicians should make the DNACPR decision that is needed and record fully their reasons for not explaining it to the patient at that time, but also ensure that there is on-going active review of the decision and of the patient's ability to accept explanation of it without harm, so that the patient is informed at the earliest appropriate opportunity.

In any situation a clinician who makes a conscientious decision not to inform a patient of a DNACPR decision, as they believe that informing the patient is likely to cause them harm, should document clearly their reasons for reaching this decision.

Other patients will indicate that they want detailed information about their care and want to be fully involved in planning for the end of their life. They may also want an opportunity to receive a second opinion should there be any disagreement (see section 14). Therefore a sensitive and skilled assessment should be made of how much

information the individual person wants to know. The decision must be the one that is right for the patient, and information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team. In considering this, clinicians should take account of the fact that people are legally entitled to see and have a copy of their health records,[24] or may be discharged home (e.g. from hospital or a hospice) with a DNACPR decision form. It may therefore be preferable for them to be informed of the existence of a DNACPR decision, and have it explained to them, rather than discover it by chance as this may be more distressing and may generate dissatisfaction or loss of trust. Where the patient has capacity, information regarding CPR should be provided to other people, including family members, only with the patient's consent (see section 12).

5.3 DNACPR decisions where CPR will not be successful and patients lack capacity

If the person lacks capacity and has appointed a welfare attorney whose authority extends to making decisions of this nature on their behalf, or if a court has appointed a deputy or guardian with similar authority to act on the individual's behalf, this attorney, deputy or guardian should be informed of the decision and the reason for it (see section 10). If the welfare attorney does not accept the decision, a second opinion should be offered, whenever possible (see section 14).

When a person lacks capacity and a decision is made that CPR will not be attempted because it will not be successful, it is good practice to ensure (subject to any confidentiality restrictions expressed when the patient had capacity) that those close to patients are informed of this decision and of the reasons for it. Sensitive and careful explanation is often needed to help people to understand that the intention is to spare the patient traumatic and undignified treatment that will be of no benefit, as they are dying, not to withhold life-saving treatment, and not to withhold any other care or treatment that they need.

When a DNACPR decision is needed in the setting of an acute, severe illness with no realistic prospect of recovery it is important that the decision is not delayed (and the quality of care for the patient compromised thereby) if the patient's family members or other carers are not available immediately to have the decision explained to them. A timely decision must be made in the interests of delivering high-quality care, and that decision and the reasons for making it must be documented fully. The decision should then be explained to those close to the patient at the earliest opportunity.

5.4 Requests for CPR in situations where it will not be successful

Patients have no legal right to treatment that is clinically inappropriate. Sometimes patients or those close to them will try to demand CPR in a situation where it is clinically inappropriate. If the healthcare team has good reason to believe that CPR will not re-start the heart and breathing, this should be explained to the patient in a sensitive but unambiguous way. These decisions, and the subsequent discussions informing the patient of the healthcare team's decision, can be difficult. They should be undertaken by clinicians with the relevant training and expertise, both in assessing the likely outcome and appropriateness of CPR, and with the relevant communication skills. If the patient does not accept the decision a second opinion should be offered, whenever possible. Similarly, if those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation, a second opinion should be offered (see section 14 on responsibility for decision-making and second opinions). The courts have confirmed that there is no legal obligation to offer to arrange a second opinion in cases where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate.[25]

5.5 Communicating DNACPR decisions where CPR will not be successful

Communicating DNACPR decisions can be particularly challenging for healthcare professionals. However, failure to explain clearly to patients or those close to them that a DNACPR decision has been made, and the basis for it, can lead to misunderstanding, potentially avoidable distress and dissatisfaction, and in some instances complaint or litigation. As with any other aspect of care, healthcare professionals must be able to justify their decisions.

Sensitive communication about CPR decisions should be undertaken by professionals with training and expertise in having those discussions. Whilst the most senior healthcare professional caring for the patient carries the ultimate responsibility for a decision about CPR, there may be situations in which another member of the healthcare team is best placed to discuss and explain it to the patient or those close to the patient.

In most cases it is helpful to support full verbal discussion of such decisions with printed information (see section 13).

Healthcare professionals discussing and communicating CPR decisions to patients, and those close to them, should:

- offer as much information as wanted (with due regard for the patient's wishes concerning confidentiality)
- be open and honest
- use clear, unambiguous language
- use a combination of verbal discussion and printed information
- provide information in formats which people can understand; this may include the need for an interpreter or easy-to-read formats
- provide information that is accurate and consistent
- check understanding
- where possible, communicate decisions in an appropriate environment and allow adequate time for discussion and reflection

See also section 15 on recording decisions.

Box 1

6. Decisions about CPR that are based on a balance of benefits and burdens

If CPR may be successful in re-starting the person's heart and breathing for a sustained period, the potential benefits of prolonging life must be balanced against the potential harms and burdens of CPR. This is not solely a clinical decision. For the patient with capacity there should be open dialogue and shared decision-making between the patient and professionals, unless the patient declines any such discussion. For the patient who lacks capacity the requirements for an assessment and decision based on their best interests should be followed (see section 10).

People should be informed sensitively about what CPR involves and its possible risks and adverse effects, as well as its likely chance of success in their specific circumstance, to try to help them to make informed decisions about whether or not they would want it. In addition to the possible clinical effects of CPR, the information needed may include, for example, a hospice patient being informed that there is a risk that they may be transferred to an acute hospital setting for post-resuscitation care for which the hospice does not have facilities. Many people (including patients, those close to them and even some healthcare professionals) have unrealistic expectations about the likely success and potential benefits of CPR and members of the public often lack detailed understanding of what is involved. The picture gained from the media (television drama for example) seldom reflects a realistic view of the success rate, or the physical nature of CPR (see section 1). News reports have tended to describe CPR as 'life-saving treatment' without reference to those for whom it will offer no benefit or for whom it may be more likely to cause burden than benefit. While healthcare professionals, understandably, are reluctant to alarm people or deter them from treatment which may be life-prolonging, it is important that everybody contributing to decisions about CPR is aware of what is involved and of the factors that may affect the outcome. Some patients or those close to them may struggle to understand why a decision about CPR is relevant, if the person is not known to have a specific problem with their heart or breathing. Careful explanation will be needed to help them to understand that:

- cardiorespiratory arrest is part of the final stage of dying
- CPR is unlikely to be successful when someone is dying from an advanced and irreversible or incurable illness
- healthcare professionals may start CPR inappropriately when someone dies unless a DNACPR decision has been made and recorded.

Prolonging life is not always beneficial. The courts have confirmed that it is lawful to refrain from an attempt at CPR on the basis that it would not be in the person's best interests.[26,27]

In assessing the potential benefits of attempting to prolong life, it is important to consider whether cardiorespiratory arrest is likely to recur and whether the person is likely to experience unmanageable or long-term pain or other distressing adverse effects. Some patients may, despite potentially distressing adverse effects, have specific reasons for wanting to try to delay death, even if this is only for a short period of time. If such a wish is expressed, accurate information must be provided about the realistic likelihood, length and quality of survival that might be expected, and about the potential harms and burdens of attempted CPR. The patient should be invited to discuss the risks and benefits of CPR in order to reach an agreed decision on whether or not it should be attempted. Nevertheless, a clinician cannot be forced to perform any intervention that she or he considers to be harmful or against a person's interests.

Balancing benefits against harms and burdens in these cases also involves balancing rights under the Human Rights Act 1998. The Act guarantees protection for life (Article 2) but also declares that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment" (Article 3). This terminology is intended to apply to situations in which people are deliberately ill-treated or have severe indignities inflicted upon them. However, some people do not wish to be kept alive in a state of total dependency or permanent lack of awareness, or to have an undignified death. If people express such views, healthcare professionals should take these into account when decisions about CPR are being considered. They should not attempt to prolong life if it is clear that the person would not want this or would consider the likely outcome unacceptable. The duty to protect life must be balanced with the obligation not to subject the person to treatment that they would regard as inhuman or degrading.

A decision that CPR will not be attempted, because the risks outweigh the benefits, should be made only after careful consideration of all factors relevant to the patient's current situation, and after discussion with the patient (unless they refuse such discussion) or with those close to patients who lack capacity. These factors include:

- the likelihood of re-starting the person's heart and breathing for a sustained period.
- the level of recovery that can be expected realistically after successful CPR.
- the person's known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values of those who lack capacity.
- the person's human rights, including the right to life, the right to be free from degrading treatment, which may include a dignified death, and the right to respect for a private and family life.
- the likelihood of the person experiencing continuing pain or suffering that they would find intolerable or unacceptable.
- the level of awareness the person has of their existence and surroundings.

Box 2

The fact that a decision has been made to attempt CPR in the event of cardiorespiratory arrest does not mean that all other intensive treatments and procedures will also be appropriate. For example, prolonged support for multi-organ failure (e.g. artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump) in an ICU may be clinically inappropriate if the patient is unlikely to survive these other treatments, even though the heart has been re-started. Conversely some people may have a DNACPR decision in place but it may still be clinically appropriate for them to be admitted to an ICU for other treatment – for example, for haemofiltration.

After resuscitation from cardiac arrest most people will require at least a brief period of monitoring, observation and treatment in a cardiac care unit or ICU. When discussing the benefits and risks of CPR with people, it is important to ensure that this is understood. For some people it will be important to take into account the possibly reduced likelihood of benefit from CPR in those for whom organ support in an ICU would not be clinically appropriate, and through sensitive discussion to help people to understand this. However, ineligibility for multi-organ ICU support is not, in itself, justification for an automatic DNACPR decision.

6.1 'Restricted' CPR attempts

Another difficult subject is the question of whether it is appropriate to make a decision to restrict the type or extent of CPR that is to be applied in specific circumstances. Some healthcare professionals advocate that people should be considered either 'for CPR' or 'not for CPR' and that there should be no 'half-measures'. Clearly, if CPR is to be attempted, it should be performed competently. It is inappropriate to initiate resuscitation and then not try hard to achieve a successful outcome.

All other decisions should, however, be made on a balance of risk and benefit. For example, a patient receiving ventilatory and other organ support on an ICU might be considered for immediate defibrillation of a shockable cardiac arrhythmia which is causing cardiac arrest. This is likely to restore the patient to the situation that was present immediately before the arrest, and there may be treatable factors that predisposed the patient to the arrhythmia. CPR might not be considered appropriate in the same patient if they were to suffer cardiac arrest in asystole or with pulseless electrical activity, with no reversible cause and therefore with a very low probability of a successful outcome.

On occasions, in other clinical settings, some clinicians may advocate restriction of CPR to treatment of shockable

rhythms only. This can be considered safely only in an environment where there is continuous ECG rhythm monitoring by professionals competent in the immediate, correct recognition of cardiac rhythm. An advance plan to limit attempted resuscitation to defibrillation alone is not recommended. If a shockable rhythm (i.e. ventricular fibrillation or ventricular tachycardia) is not terminated by the first shock from a defibrillator, delivery of effective chest compressions increases the likelihood of successful termination of the arrhythmia (and therefore of recovery of the patient) by a second or subsequent shock.

If consideration is given to making a plan to restrict the nature or extent of CPR, this must be thought through clearly on the basis of the balance of harms, burdens and benefits to the individual patient and should be discussed with the patient (or those close to people who lack capacity). If such a decision is made for an individual the reasons justifying limitation of CPR must be documented fully in the person's health record, and detailed instructions on how the decision is to be implemented must be recorded by the healthcare professional making the decision. The decision and associated instructions should be communicated effectively to all members of the healthcare team caring for the patient.

Advance decisions about the duration of CPR to be applied in the event of a future cardiorespiratory arrest are inappropriate. The duration of any resuscitation attempt should be decided by those attempting resuscitation, based on the clinical circumstances of the arrest, the progress of the resuscitation attempt and the perceived balance of burdens, risk and benefit from continuing CPR.

6.2 Requests for CPR where the harms and burdens may outweigh the benefits

Some patients ask for CPR to be attempted, even if the clinical evidence suggests that the harms and burdens are likely to outweigh the possible benefit. Although the healthcare team may doubt whether the risks associated with CPR are justified by a very small chance of success, the individual whose life is at stake may be willing to accept that chance. Realistic information must be provided sensitively to people about the nature of CPR and the likely risks, including the risk of long-term neurological damage, but if patients still ask that no DNACPR decision be made, this should usually be respected. If they subsequently suffer cardiac or respiratory arrest, further clinical decisions must be made in accordance with the advice in this guidance, taking account of both the clinical situation at the time and the patient's wishes.

These difficult situations are a potential source of confusion. Doctors cannot be required to give treatment that is contrary to their clinical judgement, but should be willing to consider and discuss people's wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where attempted CPR has a reasonable chance of successfully re-starting the heart and breathing for a sustained period, and a person has decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. In the unusual circumstance in which the doctor responsible for a patient's care feels unable to agree to their expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, a second opinion should be sought (see section 14). Transfer of the patient's care to another doctor or team can be considered if there is still a lack of agreement and it is feasible.

6.3 Communication and discussion with patients with capacity

When a person with capacity is at foreseeable risk of cardiac or respiratory arrest, they should be offered information about CPR, about the local resuscitation policy and services, and about their role in decision-making in relation to CPR. In order to determine whether the benefits of CPR would be likely to outweigh the harms and burdens, or whether the level of recovery expected would be acceptable to the patient, there should be sensitive exploration of the patient's wishes, feelings, beliefs and values (see Box 1). People with capacity should be given opportunities to talk about CPR, but information and discussion should not be forced on unwilling patients. If people indicate that they do not wish to discuss CPR this should be respected and documented. If a best-interests decision about CPR is made by the healthcare team because the patient declined discussion about CPR or asked the healthcare team to make a decision for them, this must be documented in the health record, together with the basis for the decision. As with any other aspect of care, healthcare professionals must be able to justify their decisions.

6.4 Communication and discussion with those close to patients who lack capacity

If a person lacks capacity, any previously expressed wishes should be considered when making a CPR decision, bearing in mind that in some cases those wishes may relate to circumstances that differ substantially from the present situation, or from the circumstances of a future cardiorespiratory arrest (see section 10). Whether the benefit would outweigh the harms and burdens for a particular patient should be the subject of discussion and

agreement between the healthcare team and those close to or representing the patient. Relevant information should be shared with those close to patients unless, when they were previously competent to do so, a patient has expressed a wish that information be withheld.

Consulting with those close to patients in these circumstances is not only good practice[28] but is also a requirement of the Human Rights Act (Articles 8 – right to private and family life and 10 – right to impart and receive information), and is ordinarily a requirement of the Mental Capacity Act 2005 (England and Wales), and the Adults with Incapacity (Scotland) Act 2000 (see section 10).

The NHS Constitution for England also notes that people have the right to be involved in discussions and decisions about their health and care, including their end-of-life care, and to be given information to enable them to do this. Where appropriate this right includes their family and carers.[29]

Clinicians should ensure that those close to the patient, who have no legal authority to make decisions for the patient, understand that their role is to help inform the decision-making process, rather than being the final decision-makers. Great care must be taken when people other than the patient make or guide decisions that involve an element of quality-of-life assessment, because there is a risk that healthcare professionals or those close to the patient may see things from their own perspective and allow their own views and wishes to influence their decision, rather than those of the patient. These considerations should always be undertaken from the patient's perspective. An important factor is whether the patient (if they had capacity) would regard the level of possible recovery acceptable, taking into account the invasiveness of CPR and its likelihood of success in the individual circumstances under consideration, not whether it would be acceptable to the healthcare team or to those close to the patient, nor what they would want if they were in the patient's position.

7. Circumstances when a CPR decision may not be followed

There are circumstances in which a CPR decision has been documented in advance, but when the patient suffers cardiorespiratory arrest the attending healthcare professionals assess the situation and make a decision to act contrary to the previously documented decision. Examples of such situations are outlined below.

7.1 Contemporaneous clinical assessment

Unless there is a valid and applicable advance decision (ADRT) refusing CPR, a CPR decision form is not 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 death or cardiorespiratory arrest. The final decision regarding the application or not of the CPR decision in an emergency rests with the healthcare professionals responsible for managing the patient's immediate situation. The healthcare professional may, on attending an arrest, make a clinical assessment resulting in a different decision to the one on the CPR decision form. As with any clinical decisions, healthcare professionals must be able to justify their decision. In particular, clinicians should be cautious of overriding a DNACPR decision where the CPR decision form records that the patients has expressed a clear wish not to receive attempted CPR.

7.2 Not the envisaged circumstances

Occasionally, some people for whom a DNACPR decision has been made may develop cardiac or respiratory arrest from a readily reversible cause such as choking, a displaced or blocked tracheal tube, or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the person has made a valid refusal of the intervention in these circumstances. To avoid misunderstandings it may be helpful, whenever possible, to make clear to patients and those close to patients that DNACPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest and not to an unforeseen event such as a blocked airway.

7.3 Temporary suspension

In addition to readily reversible causes, it may be appropriate to suspend a decision not to attempt CPR temporarily during some procedures, if the procedure itself could precipitate a cardiorespiratory arrest, especially if there is a high probability that prompt treatment of the arrest may be effective. For example, cardiac catheterisation, pacemaker insertion, or surgical operations

may occasionally trigger cardiorespiratory arrest.[30] General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment, which may include CPR. Many routine interventions used during anaesthesia (for example tracheal intubation, mechanical ventilation or injection of vasoactive drugs) may also be regarded as resuscitative measures.

Under these circumstances, where a cardiorespiratory arrest and its cause can be treated promptly, survival rates are much higher than those following many other causes of in-hospital cardiac arrest. DNACPR decisions should be reviewed in advance of the procedure. This should be discussed with the patient, or their representative if they lack capacity, as part of the process of seeking informed consent for the procedure. Some patients may wish a DNACPR decision to remain valid despite the risk of a cardiorespiratory arrest from a reversible cause; others will request that the DNACPR decision is suspended temporarily. The time at which the DNACPR decision is reinstated should also be discussed, agreed in advance and documented.

If a patient wants a DNACPR decision to remain valid during a procedure or treatment that carries some risk of cardiorespiratory arrest this may increase the mortality risk of the procedure or treatment. As an extreme example, some cardiac surgical procedures require induction of cardiac arrest as a necessary part of the procedure, so treatment could not be completed successfully without reversal of that arrest by defibrillation. If a clinician believes that a procedure or treatment would not be successful or would be unacceptably hazardous with the DNACPR decision still in place, it would be reasonable not to proceed. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) has published specific guidance on management of DNACPR decisions in the perioperative period.[31] In the event of disagreement the patient should be offered a second opinion (see also section 17 on reviewing decisions).

8. Initial presumption in favour of CPR when there is no recorded CPR decision

If no explicit decision has been made in advance about CPR and the express wishes of a person are unknown and cannot be ascertained, there should be an initial presumption that healthcare professionals will make all reasonable efforts to resuscitate the person in the event of cardiac or respiratory arrest. In such emergencies there will rarely be time to make a comprehensive assessment of the person's condition and the likely outcome of CPR. In these circumstances initiating CPR will usually be appropriate, whilst all possible efforts are made to obtain more information that may guide further decision-making. Healthcare provider organisations and healthcare professionals should support anyone initiating and delivering CPR in such circumstances.

There will be some situations in which CPR is started on this basis, but during the resuscitation attempt further information becomes available that makes CPR inappropriate. That information may include a fully documented DNACPR decision, a valid and applicable advance decision to refuse treatment (ADRT) (see section 9), or clinical information indicating that CPR will not be successful. In such circumstances, continuing attempted resuscitation would be inappropriate.

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 DNACPR decision has been made. 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.

9. Refusals of CPR by adults with capacity

Clearly people will lack capacity at the time of suffering cardiac or respiratory arrest, but anticipation of a possible arrest may enable them to decide in advance whether or not they want CPR to be attempted (see section 2).

It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where healthcare teams believe that CPR may be successful in re-starting a person's heart and breathing for a sustained period, discussion should take place with that person to determine their views and wishes regarding CPR. If people decide that they do not wish to have CPR attempted, this should be documented clearly in their health records (whether hospital, GP or healthcare establishment's records) and steps should be taken to ensure that this is communicated to those who need to know (see section 16). People are not obliged to justify their decisions about their future treatment, but healthcare professionals usually wish to discuss the implications of a refusal of treatment with people in order to ensure that the decision is based on accurate information and not on any misunderstanding; however they must take care not to pressure people into accepting treatment that they do not want. Some people may be content for their refusal of CPR simply to be documented in their health record but they should be informed that if they want the refusal to be binding, in England and Wales, they should make a formal ADRT following the criteria stipulated in the Mental Capacity Act 2005 (England and Wales).

9.1 Advance decisions refusing CPR

CPR must not be attempted if it is contrary to a valid and applicable ADRT (sometimes referred to as a 'living will') made when the person had capacity (see below for criteria for validity).

In **England and Wales**, advance decisions are covered by the Mental Capacity Act 2005. The Act confirms that an ADRT refusing CPR will be valid, and therefore legally binding on the healthcare team, if:

- the person was 18 years old or over and had capacity when the decision was made
- the decision is in writing, signed and witnessed
- it includes a statement that the advance decision is to apply even if the person's life is at risk
- the advance decision has not been withdrawn
- the person has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- the person has not done anything clearly inconsistent with its terms
- the circumstances that have arisen match those envisaged in the advance decision.

If an ADRT does not meet these criteria but appears to set out a clear indication of the person's wishes, it will not be legally binding but should be taken into consideration in determining the person's best interests. A number of examples of ADRTs can be found in the public domain.[32]

Some people have tried to maximise the likelihood that their wishes are respected by having a tattoo, usually on their chest, with the words 'Do not resuscitate' or similar. On its own it does not constitute a legally binding ADRT but should be taken into consideration when assessing a person's previously expressed views and wishes, in order to make a decision in their best interests. Where a person has taken such a measure, and where this is regarded as a fully informed decision by a person with capacity, that person should be encouraged to make a formal, written ADRT in addition.

In **Scotland and Northern Ireland**, ADRTs are not covered by statute but it is likely that they are binding under common law. Although no cases have been taken to court in Scotland or Northern Ireland, it is likely that the principles that emerged from consideration of cases by the English courts (before the Mental Capacity Act) would also guide decision-making in these jurisdictions. Should case law change in this area, this guidance will be revised to reflect any changes.

An advance refusal of CPR is likely to be legally binding in Scotland and Northern Ireland if:

- the person was an adult at the time the decision was made (16 years old in Scotland and 18 in Northern Ireland)
- the person had capacity when the decision was made
- the circumstances that have arisen are those that were envisaged by the person
- the person was not subjected to undue influence in making the decision.

If an ADRT does not meet these criteria but appears to set out a clear indication of the person's wishes, it will not be legally binding but should be taken into consideration in determining the person's best interests.

9.2 Assessing validity and applicability

Although an ADRT may not come to light until a person has lost capacity, there should be a presumption that the person had capacity when an advance decision was made, unless there are grounds to suspect otherwise. The onus is on patients to ensure that healthcare teams will be made aware of the existence and content of any ADRT. Ensuring that their family and others close to them are fully aware of the existence and location of the ADRT document will help to maximise the likelihood that their instructions are followed.

Healthcare professionals must decide whether the ADRT is applicable to the circumstances that have arisen. Particular care will be needed where an ADRT has not been reviewed or updated for a long time and attention should be given to any relevant clinical developments or changes in the person's personal circumstances since the decision was made. For example, some people may have taken actions or made other important decisions that indicate that they had changed their mind.

Where there is genuine doubt about the validity and applicability of an ADRT (and when time permits) further enquiries should be made and, if necessary, an application made to the Court of Protection (in England and Wales), the Sheriff Court (in Scotland) or the High Court (in Northern Ireland) for a judgment. In an emergency, where there is no time to investigate further, the presumption should be in favour of CPR if this has a realistic chance of prolonging life. If it is agreed that an ADRT is invalid or not applicable the reasons should be documented.

10. Adults who lack capacity

This section explains who should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales) and the Adults with Incapacity (Scotland) Act 2000 concerning proxy decision-makers.

Decision-making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast, to decisions about serious medical treatment, for example CPR. Adults should be assumed to have capacity unless there is clear evidence to the contrary. A person is regarded as legally unable to make a decision for themselves if they are unable to do any of the following:

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

More detailed guidance on mental capacity legislation, including when to make formal capacity assessments can be found on the BMA's website at www.bma.org.uk/ethics

10.1 Adults who lack capacity and have (i) not appointed a welfare attorney or other legal surrogate or (ii) not made an advance decision refusing CPR – but do have family and/or friends

Where a patient has not appointed a welfare attorney or made an advance decision, the treatment decision rests with the most senior clinician responsible for the patient's care. Where CPR may re-start the patient's heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient's best interests (or 'benefit' in Scotland). In order to assess best interests, where possible the views of those close to the patient must be sought, to determine any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR.

In reaching a decision:

- In **England and Wales** the Mental Capacity Act requires that best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, and anyone engaged in caring for the person or interested in the patient's welfare. Under the Act, all healthcare professionals must act in the best interests of a patient who lacks capacity.
- In **Scotland** the Adults with Incapacity (Scotland) Act requires doctors to take account, so far as is reasonable and practicable, of the views of patients' nearest relatives and their primary carers. If a senior clinician believes that CPR should be attempted, any person claiming an interest in the patient's welfare may appeal that decision to the Sheriff. A DNACPR decision could also be challenged in the Court of Session.
- In **Northern Ireland**, where there is no statutory provision for decision-making for people who lack capacity, it is nonetheless good practice to discuss decision-making with those close to the patient in order to determine what would be in the best interests of the patient.

In these circumstances, it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient, but to help the healthcare team to make an appropriate decision in the patient's best interests. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision-making but that they cannot insist on a treatment or on withholding or withdrawal of a treatment.

As described in sections 5.3 and 6.4, it is important that a decision about CPR is not delayed inappropriately (and the quality of care for the patient compromised thereby) if the patient's family members or other carers are not available immediately to discuss a best-interests decision or to have a DNACPR decision explained to them where CPR would not be successful. In that situation the senior healthcare professional responsible for the patient's care should make and document the decision, and ensure that those close to the patient are consulted and/or have the decision explained to them at the earliest opportunity.

10.2 People with a welfare attorney or court-appointed deputy or guardian

If people lack capacity and have a welfare attorney or guardian, this person must be consulted about CPR decisions that are made on a balance of benefits and risks. However, if CPR would not be successful, welfare attorneys and guardians should be informed of the resulting DNACPR decision and the reasons for making it (see section 14 on responsibility for decision-making and second opinions).

In **Northern Ireland** there is currently no provision for anybody to make decisions on behalf of people who lack capacity, although those close to patients should be consulted where a best-interests decision is being made by the clinician responsible for the person's care.

In **England and Wales** the Mental Capacity Act allows people over 18 years of age who have capacity to give Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make health and personal welfare decisions on their behalf once such capacity is lost. The Court of Protection may, on application, appoint a deputy with similar powers. Before relying on the authority of this person, the healthcare team must be satisfied that:

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

Neither welfare attorneys nor deputies can demand treatment that is clinically inappropriate. Where CPR may be able to re-start the heart and breathing for a sustained period and a decision on whether or not to attempt CPR is based on the balance of benefits and risks, views of the attorney or deputy about a patient's best interests must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney or court-appointed deputy about whether CPR should be attempted in the event of cardiorespiratory arrest, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration. More information about welfare attorneys, deputies and the Mental Capacity Act can be found in the Mental Capacity Act code of practice.[33]

In **Scotland**, the Adults with Incapacity (Scotland) Act allows people over 16 years of age, who have capacity, to appoint a welfare attorney to make decisions about medical treatment once capacity is lost. The Sheriff may, on application, appoint a welfare guardian with similar powers. Before relying on the authority of a welfare attorney or guardian, the healthcare team must be satisfied that:

- the person lacks capacity to make the decision for himself or herself (the terms of a power of attorney may state how incapacity is to be determined)
- the welfare attorney or guardian has the specific power to consent to treatment (a register of valid proxy decision makers is held by the Public Guardian and may be checked during office hours)
- the decision being made by the attorney or guardian would benefit the patient
- the attorney or guardian has taken account of the patient's past and present wishes as far as they can be ascertained.

Welfare attorneys and guardians cannot demand treatment that is clinically inappropriate. Where CPR may be able to re-start the heart and breathing for a sustained period and a decision on whether or not to attempt CPR is based on the balance of benefits against harms and burdens, the

welfare attorney's views about a patient's likely wishes must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney about whether CPR should be attempted in the event of cardiac or respiratory arrest, this should be resolved as quickly as possible by discussion and, if necessary, a second clinical opinion.

If the healthcare team wishes to attempt CPR but the welfare attorney or guardian refuses to give consent, the Mental Welfare Commission for Scotland must appoint a 'nominated medical practitioner' to give an opinion. This opinion is final unless appealed to the Court of Session. If the healthcare team does not believe that attempting CPR would benefit the patient, and the welfare attorney disagrees, either party could petition the Court of Session for a decision. More information about the Adults with Incapacity (Scotland) Act can be found in the Adults with Incapacity Act code of practice.[34]

10.3 Adults who lack capacity and have no family, friends or other advocate who it is appropriate to consult

In **England and Wales**, the Mental Capacity Act 2005 requires consultation with an independent mental capacity advocate (IMCA) regarding all decisions made by an NHS body or Local Authority about 'serious medical treatment', where people lack capacity and have nobody to speak on their behalf. The definition of serious medical treatment includes circumstances where "what is proposed would be likely to involve serious consequence for the patient". It can be argued that a decision not to attempt CPR because it will not work will not have 'serious consequences' for the patient, because the patient will die with or without attempting CPR. For this reason, in our view, it is not necessary to consult an IMCA when it is clear to the medical team that CPR would not re-start the patient's heart and breathing for a sustained period. Nevertheless, neither the Act, nor the code of practice, differentiates between decisions made purely on clinical grounds (i.e. because the treatment is unable to achieve its clinical aim) and those that involve broader best-interests considerations and so it should be acknowledged that there is still some uncertainty in this area. Where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a decision about CPR is being considered on the balance of benefits and risks, in order to comply with the law an IMCA must be involved in every case. If a CPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and the reasons for it should be recorded in the health record and an IMCA should be consulted at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician responsible for the person's care as part of the determination of that person's best interests.

11. Children and young people under 18 years of age

Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, parents and the healthcare team.[35]

As with adults, decisions about CPR must be made on the basis of an individual assessment of each child or young person's current situation. It is not necessary to initiate discussion about CPR if there is no reason to believe that the child is likely to suffer a cardiorespiratory arrest. If CPR will not re-start the heart and breathing, it should not be attempted. Often these decisions are made in the context of a wider decision-making framework. For example, in Scotland, as part of the *Children and Young Persons Acute Deterioration Management (CYPADM)* framework.[36]

As with adults, difficulties can arise where CPR may re-start the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the potential harms and burdens. In these cases the views of the child or young person should be taken into consideration, where possible, in deciding whether or not CPR should be attempted.

Usually, it is possible to reach agreement on whether or not CPR should be attempted. If it is not possible to reach agreement between the patient, the individuals with parental responsibility and the healthcare team, legal advice should be sought. Doctors cannot be required to provide treatment contrary to their professional judgement, but doctors should try to accommodate the child's and parents' wishes where there is genuine uncertainty about the young person's best interests. If legal advice is required, this should be sought in a timely manner.

Where a competent young person makes an informed advance refusal of CPR, healthcare professionals should seek legal advice if they believe that CPR would be beneficial to the young person. In **England, Wales and Northern Ireland**, refusal of treatment by competent

young people up to the age of 18 is not necessarily binding upon doctors. The courts have overridden competent young people's refusal of life-saving treatment in the past. Where a young person who is competent refuses treatment, the potential harm caused by violating the young person's choice must be balanced against the risk from not giving treatment – in the case of CPR, this will result in a missed opportunity to try to save the life of the young person. In **Scotland**, it is likely that neither parents nor the courts are entitled to override a mentally competent young person's decision, but healthcare professionals are still advised to seek legal advice as the matter is not beyond doubt. Information about significant legal developments relevant to this guidance will be made available on the BMA's website at www.bma.org.uk/ethics

As noted above, a young person's refusal is not necessarily binding but young people who are competent to do so are entitled to give consent to medical treatment. Where they are not competent it is generally those with parental responsibility[37] who make decisions on their behalf. Young people 16 years of age and over are assumed to be competent to consent to medical treatment unless there is evidence to the contrary. Young people under the age of 16 can also be assessed to be competent to consent to medical treatment. Competent children and young people who are under the age of 16 are sometimes referred to as being '*Gillick* competent'.[38]

Mental capacity legislation also applies to young people aged 16 and over who lack capacity (see section 10) with some exceptions. For example, they cannot make Advance Decisions to Refuse Treatment (ADRTs) or Lasting Powers of Attorney (LPAs) under the legislation in England and Wales. Further, more detailed, guidance on decision-making for under-18-year-olds can be found on the GMC and BMA websites at www.gmc-uk.org/guidance and www.bma.org.uk/ethics

12. Confidentiality

If adults have capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing information with others, including family and friends. It may also be helpful to ask people with capacity who they want, or do not want, to be involved in decision-making if they become incapacitated (although it should be made clear that unless this person is formally appointed as a welfare attorney their role will be limited to providing information for the healthcare professional who decides about treatment). Refusal by a person with capacity to allow information to be disclosed to family or friends must be respected. Whilst this may present difficulties in discussing care with people close to the patient, healthcare professionals should explain, with due sensitivity and empathy, their duty of confidentiality to the patient and that disclosure of information has been limited explicitly by the patient.

Where people lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to those close to the patient where this is necessary to discuss the patient's care and is not contrary to the patient's interests. Even where their views have no legal status in terms of actual decision-making, it is good practice to involve people close to patients in discussions that inform decisions. Where there is a welfare attorney, deputy, or guardian involved in the discussions, relevant information should be provided to them to enable them to fulfil their role. Where an IMCA is involved they have a legal right to information, including access to the relevant parts of the patient's health records, in order to enable them to carry out their statutory role (see section 10.3).

In general children and young people are content for their parents to be involved in their care, however, the same principles of confidentiality for adults apply also to all children and young people. If a child or young person is reticent to involve his or her parents every reasonable effort must be made to persuade the child to involve parents or guardians, particularly for important or life-changing decisions. Where the child is not competent and does not want parental involvement, the GMC advises that where "it is necessary in the child's best interests for the information to be shared (for example, to enable a parent to make an important decision, or to provide proper care for the child), you can disclose information to parents or appropriate authorities".[39]

13. Provision of information in printed and other formats for patients and those close to patients

Although printed information should never be used as a substitute for clear and full verbal discussion and provision of information, printed information should be used as well, both to raise people's awareness of the importance of decisions about CPR and to supplement or reinforce information provided in discussion.

Healthcare organisations (including hospitals, hospices, general practices, ambulance services and care homes) should include information about their CPR policies, in the general literature provided to patients and the public. Those policies, whilst primarily intended to direct staff, should also be accessible by patients and the public, should they wish to examine them.

In addition specific information about CPR and about decisions relating to CPR should be readily available and offered in printed format to patients at foreseeable risk of dying or suffering sudden cardiorespiratory arrest, to those close to them when appropriate and to others who express a wish to know more about or discuss CPR. The BMA, Resuscitation Council (UK) and RCN have produced a model information leaflet, addressing some of the common questions that people ask, or may want to ask. It should be amended to include local information, and is available on the websites of the three organisations.

Some organisations may wish to provide information in additional ways, for example using a digital video recording. These should be regarded as supplementary to and not a substitute for verbal and printed information.

Provision of information should aim to de-mystify the process by which CPR decisions are made. It should make clear that, although for many people the need to make a decision about CPR will not arise, for many others discussion of their wishes regarding CPR is a routine and important part of providing them with high-quality care. Information should explain to people their part in decision-making, what facilities are available, and in general terms what situations it is likely that CPR may be or will not be successful.

14. Responsibility for decision-making

The overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician responsible for the person's care as defined explicitly by local policy. This could be a consultant, general practitioner (GP) or suitably experienced and competent nurse. He or she should always be prepared to discuss a CPR decision with other healthcare professionals involved in the person's care. Wherever possible and appropriate, a decision about CPR should be agreed with the whole healthcare team. Teamwork and good communication are of crucial importance in the delivery of high-quality care. If there is doubt or disagreement about the most appropriate decision, a second opinion should be sought. The GMC advises that "a second opinion should be from a senior clinician with experience of the patient's condition but who is not directly involved in the patient's care. It should be based on an examination of the patient by the clinician".[40] Where a DNACPR decision is made on clinical grounds, because there is no realistic chance that CPR will be successful, there is no legal obligation to offer a second opinion, especially in cases where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate.[41] Nevertheless, if the patient or those close to a patient do not accept a DNACPR decision a second opinion should be offered, where possible, in the course of good clinical practice.

Where care is shared, for example between hospital and general practice, or between general practice and a care home, the healthcare professionals involved should discuss a decision about CPR with each other and with other members of the healthcare team. There should be shared responsibility for deciding about the likelihood of a successful outcome from CPR, and discussing the subject with the patient or with those close to patients who lack capacity where appropriate. Nevertheless, one individual must take charge of ensuring that the decision is made properly, is recorded properly and communicated to all those who need to know it, including locum staff. Local policies should specify who that responsible individual should be.

Unless the CPR decision form documents a valid ADRT for the circumstances encountered by the attending team (ADRTs apply only in England and Wales: see sections 9.1-9.2), a CPR decision form is not legally binding and should be regarded as a clinical assessment, recorded to try

to guide immediate clinical decision-making in the event of a patient's death or cardiorespiratory arrest. The final decision regarding the application of the CPR decision in an emergency rests with the healthcare professionals dealing with the patient in the immediate situation.

15. Recording decisions

Any decision about whether or not to attempt CPR must be recorded clearly in the patient's current health record, and should be available immediately and easily to all healthcare professionals who may need to know it, including staff of hospitals, hospices and nursing homes, GPs and other community healthcare professionals, out-of-hours medical services, and ambulance clinicians.

The CPR decision form itself should contain sufficient detail to allow a healthcare professional facing an emergency situation to assess quickly and easily the basis on which the decision was made, the people involved in making the decision (including the patient and if not, reasons why not), and others who have been informed of the decision. In many circumstances it is necessary to record additional information in the text of the patient's health record. When a CPR decision form is transferred with a patient, this fact should be documented in the health record.

The BMA, Resuscitation Council (UK) and RCN believe that there are clear benefits in having such decisions recorded on standard forms that are compliant with legislation and recognised across geographical and organisational boundaries within the United Kingdom. Such forms would be familiar to staff who move between healthcare settings, and would help to ensure that appropriate and carefully considered decisions are respected when a patient moves between healthcare settings or travels away from their usual place of residence. Such forms may give assurance to those responsible for implementing a CPR decision that appropriate procedures have been followed and the decision has been made and authorised appropriately. Scotland, and some English regions or healthcare communities already have standard forms in place[42] and Wales and Northern Ireland are currently developing one. In 2009 the Resuscitation Council (UK) defined standards and developed model forms for recording DNACPR decisions for use in England and Wales. These forms can be adapted as necessary for local use and are available at www.resus.org.uk and will be reviewed and modified at intervals in the light of evolving evidence, changing clinical practice and developments in the law. The BMA, Resuscitation Council (UK) and RCN recognise the development of and increasing preference for forms that record decisions about CPR as part of a care plan that records other treatment options. Contributions are being made to the current work in England towards standardisation of documentation in relation to decisions about CPR.

Good documentation includes the following, either on the CPR decision form or in the main health record:

- the decision, including date and time
- detailed reasons for making the decision
- name and position of the person making the decision
- name and position of the person recording the decision
- if that is not the senior responsible clinician, the name and position of the senior responsible clinician, who should review and if appropriate endorse the decision at the earliest opportunity
- details of any discussions about the decision with the patient and with those close to them, and (for a person who does not have capacity) with any person with authority to make decisions on their behalf and/or with an IMCA
- where no discussions have taken place the reasons for this
- what information was offered to the patient and those close to them
- members of the healthcare team who contributed to the decision
- if a second opinion was requested, details of that request and of the response
- details of any legal advice sought
- a formal assessment of the patient's capacity, where necessary
- the existence and identity or the absence of an individual with legal authority to make decisions for a person who lacks capacity.

Model CPR decision forms can be found on the Resuscitation Council (UK) website at www.resus.org.uk

Box 3

In general we recommend that CPR decision forms should not be copied, to avoid the possibility that inappropriate clinical decisions or actions result from a copy of a form that relates to a decision that has been cancelled. If copying is permitted, a clear policy should be in place to ensure that

there is a mechanism to cancel all copies in the event of the decision being cancelled. A similar policy should be in place to ensure prompt cancellation of any centrally-held paper or electronic record (for example by an ambulance control centre or out-of-hours service) if a decision about CPR is changed.

15.1 Electronic records

Increasingly, people (in particular those receiving end-of-life care) may have CPR decisions recorded electronically in a central database that is accessible by various healthcare providers. This may include ambulance services, out-of-hours services, general practices, hospitals and others. Where such databases are used, there is a possibility that a healthcare professional responding to an emergency may be told of the existence of a CPR decision or of an ADRT, but may not be able to see the content of those documents to check their validity. Where such databases are used they should be accompanied by a clear policy on what action is to be taken when personal access to the documents is impossible. Wherever possible, such databases should have arrangements in place for relevant documents to be accessed electronically in an emergency situation.

Decisions relating to CPR must be documented fully and clearly in both electronic and paper records. Healthcare providers using electronic records should have systems in place to ensure that decisions relating to CPR are available as soon as they are required. The format and content of an electronic CPR decision form should be similar to that of a paper CPR decision form.

15.2 Co-signing of CPR decision forms

In the past, in some paediatric settings, parents have been asked to sign CPR decision forms. This is not advisable and can cause unnecessary additional distress. Some healthcare professionals have suggested that adult patients should sign CPR decision forms, in a similar way that patients provide signed consent to treatment, such as an operation. This is not a legal requirement. Such a policy could be an obstacle to effective end-of-life care for some dying patients for whom discussions about CPR decisions will be potentially harmful and unnecessary. There is no requirement for those close to patients to sign forms to confirm their agreement with/to a DNACPR decision. Asking them to do so could contribute to them inferring incorrectly that they are being asked to make the decision. It is common for those close to patients to misinterpret or forget precise detail of what they are told at such times, when they are understandably anxious and often tired. For this reason it is crucial that healthcare professionals document details of such discussions and explanations clearly in the patient's health records.

16. Communicating decisions to other healthcare providers

The healthcare professional responsible for a CPR decision is also responsible for ensuring that the decision is communicated effectively to other relevant healthcare professionals in both primary and secondary care, including ambulance clinicians and staff of residential and nursing homes. Local policies should specify both a clear line of responsibility and the responsibilities of specific individuals. The task of disseminating information may be delegated to another member of the healthcare team, but it should be clear who has responsibility for ensuring that this task is being undertaken effectively. The senior nurse is responsible for ensuring that every CPR decision is recorded in the nursing records (where the institution has separate nursing records), that those records are updated should the decision change and that all those nursing the patient are aware of the current decision.

16.1 Patient transfer

Transfer of patients from one setting to another presents particular challenges in relation to decisions relating to CPR and their documentation. This has been highlighted by examples of inappropriate CPR being applied to people being transferred between healthcare organisations, because a DNACPR decision was not communicated effectively or because the healthcare organisation transferring or receiving the patient did not accept a decision by another healthcare organisation. In some instances this has been compounded by unnecessary involvement of police or the coroner following an expected death during transfer. This emphasises the importance of effective communication between healthcare professionals involved in all aspects of a person's care and the importance of policies that allow clinical decisions, and the documents used to record them, to cross geographical and organisational boundaries.

Any decision about CPR should be communicated between healthcare professionals whenever a patient is transferred between establishments, between different areas or departments of one establishment, or is discharged home from a healthcare establishment. The General Medical Council (GMC) places a professional obligation on doctors to follow agreed systems and ensure good communication:

> "You should check the handover arrangements where you work, and use the available systems and arrangements for information storage and exchange, to ensure that the agreed care plan is shared within

> the healthcare team, with both paid and unpaid carers outside the team and with other healthcare professionals involved in providing the patient's care.
>
> This is particularly important when patients move across different care settings (hospital, ambulance, care home) and during any out-of-hours period. Failure to communicate some or all relevant information can lead to inappropriate treatment being given (for example, DNACPR decisions not being known about) and failure to meet the patient's needs (for example, their wish to remain at home not being taken into account)."[43]

The Nursing and Midwifery Council (NMC) places a professional obligation on nurses and midwives:

> "You must keep your colleagues informed when you are sharing the care of others."[44] And "You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care."[45]

There are many examples – at local, regional and national levels – of ways of ensuring that decisions are disseminated to all those involved in the care of patients. For example, as noted in the previous section, agreeing standard CPR decision forms that are recognised locally, regionally or nationally by all healthcare establishments, the police, out-of-hours service providers, and ambulance service. These forms may be transferred with the patient or held (usually electronically) in an agreed central location.

Commissioners have an opportunity to ensure that healthcare provider organisations have robust systems in place for recording, communication and cross-boundary transfer of decisions relating to CPR. This would encourage providers of healthcare to collaborate to ensure that people do not receive inappropriate treatment because of failure to operate such cross-boundary arrangements.

Where a CPR decision has been recorded on a paper form that is recognised and accepted by other healthcare providers it is recommended that the form travels with the patient, to ensure continuity. However this requires particular care to make certain that the patient is aware of and understands and accepts the continuing CPR decision and the reasons for it.

As emphasised in previous sections, decisions relating to CPR are best made as shared decisions between patients and their healthcare professionals whenever possible and appropriate. However some patients may forget previous discussions and agreements, particularly if they have been very unwell or there has been a long period between the decision and the time of transfer. In some clinical settings discussion of the decision may have been impossible or inappropriate due to the person's health at the time of the decision, or may have been declined by the patient. In many circumstances involving the patient in the decision-making process through discussion or explanation is required under Article 8 of the Human Rights Act (see section 4). As also emphasised in section 5, sensitive explanation to a patient of a CPR decision and of the form on which it is recorded is usually better than the patient discovering the decision by chance. The transfer of a CPR decision form with a patient greatly increases the importance of this. Prior to transfer, where appropriate, the continued relevance of a CPR decision and the reason for transfer with them of a CPR decision form should be discussed with and explained to patients.

16.2 Ambulance clinicians

As described in section 16.1, problems have arisen previously when transferring patients between different settings because CPR decisions were not communicated or were not accepted as valid by the ambulance service or by the receiving organisation. Clinical guidelines issued by the Association of Ambulance Chief Executives[46] advise ambulance clinicians that in the presence of cardiopulmonary arrest they should always initiate CPR unless the patient has a condition unequivocally associated with death, specifically massive cranial and cerebral destruction, hemicorporectomy or similar massive injury, rigor mortis, hypostasis, decomposition/ putrefaction or incineration.

The ambulance service guidelines state also that resuscitation can be discontinued where there is a formal DNACPR 'order' or an Advance Decision (Living Will) that states the wish of the patient not to undergo attempted resuscitation, or where a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNACPR decision has been made.

Readers are urged to read the full Ambulance Services guidelines if more detailed information on ambulance clinicians' response to cardiorespiratory arrest is required.

To ensure that ambulance clinicians do not start CPR against the recorded wishes of the patient, it is important that ambulance services have robust systems in place to record ADRTs and decisions about CPR, and to communicate these immediately to ambulance clinicians who respond to an emergency call to a patient for whom such a document exists. With increasing use of electronic records such documents may be stored centrally. As ambulance clinicians have to satisfy themselves that the document exists and is valid in the circumstances encountered, an agreed method of emergency communication of any such decision, and of the basis for it, is necessary and should be subject to clinical governance.

As noted earlier, local resuscitation policies should make clear how CPR decisions are to be communicated and who is responsible for ensuring that this happens. In drawing up a local protocol, involvement of all local healthcare providers, in particular the ambulance service and out-of-hours service providers, is essential. Acceptance and recognition of the protocol by the police and coroner or procurator fiscal's office should be sought to ensure that when a death occurs in the community with a DNACPR decision in place, this is treated as an expected death.

17. Review

Decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person's condition or in their expressed wishes. This applies to a decision that CPR is appropriate as well as to a DNACPR decision. The frequency of review should be determined by the healthcare professional responsible for their care and will be influenced by the clinical circumstances of the patient. Nevertheless, local policies should include some general safeguards for ensuring that review occurs appropriately and that any changes in CPR status are discussed and communicated properly. Although some healthcare organisations try to address this by having a specified period after which a DNACPR decision must be reviewed to remain valid, this has potential risks. Failure to renew the DNACPR decision at the appropriate time may result in people receiving CPR that is clinically inappropriate. Also rigid review times may distract healthcare professionals from the need for more frequent review in some patients, leaving DNACPR decisions or decisions to attempt CPR in place when they are no longer appropriate. There will be some patients for whom a DNACPR decision will be appropriate until their death and therefore review of this decision is not necessary; documentation should be sufficiently flexible to allow for these various different circumstances.

It is important to note that patients' ability to participate in decision-making may change with changes in their clinical condition. It may not always be necessary to discuss CPR with the patient each time the decision is reviewed. The need to discuss the decision further with the patient should be determined by careful assessment in each individual situation. Where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it. Where that decision was a shared decision with the patient (or their welfare attorney), based on a balance of benefits against harms and burdens of CPR, revision of that decision should include discussion with the patient (or those close to the patient if they have subsequently lost capacity) (see section 6).

The required frequency of review of CPR decisions may differ greatly between different types of care setting. It may also differ greatly between individual patients within any one care setting, so the frequency must be based on the needs of the individual patient and not on any 'blanket' policy. For example, in a palliative care environment frequent review of DNACPR decisions will not be necessary for many patients, but the healthcare staff should be competent to recognise those whose situation warrants more frequent review of the decision.

In its report on cardiorespiratory arrests in hospitals – *Time to Intervene* – the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommended that "CPR status must be considered and recorded for all acute (hospital) admissions, ideally during the admission process and definitely at the initial consultant review when an explicit decision should be made in this group of patients, and clearly documented (for CPR or DNACPR)".[47] As noted earlier in this guidance, although the NCEPOD recommends that CPR should be considered for all acute admissions, it does not mean that it is necessary to discuss CPR with all patients admitted to hospital acutely. There are some patients who are dying from an advanced and incurable illness, for whom CPR will not work and for whom a discussion is likely to cause them to suffer harm (see section 5).

Healthcare professionals dealing with acute medical emergencies should be supported with appropriate training to enable them to assess in each patient the risk

of cardiorespiratory arrest and the likelihood of successful outcome from CPR. They should also be trained to undertake appropriate discussions about CPR with patients and those close to them. When critically ill patients are assessed in this way and decisions are made about CPR, it is important that there is appropriately senior (usually consultant) involvement in the decision. Early decisions about CPR in critically ill patients must be subject to frequent review. Hospital systems should be in place to ensure that this requirement is not compromised by the transfer of patients to different healthcare teams and to different wards or care units. Some patients for whom a DNACPR decision is made when they are critically ill, and unlikely to survive cardiorespiratory arrest, may respond to treatment (over a period of hours or days) sufficiently to warrant review and possible cancellation of that decision. Other patients who were considered 'for CPR' at the time of their admission (usually because of a hoped-for or expected improvement with treatment) may fail to respond to treatment and deteriorate progressively (over a period of hours or days or longer), indicating a low prospect of survival to hospital discharge and a requirement for review and probable reversal of the decision to use CPR. In acutely ill people, review and, when appropriate, revision of decisions about CPR should be as responsive to changes in the patient's clinical condition and physiological observations as review and revision of any other aspect of their treatment.

18. Standards, audit and training

CPR decisions and their communication can be sensitive and complex. They should be undertaken by appropriately trained, competent and experienced members of the healthcare team. Organisations providing healthcare must ensure that their clinical staff have adequate training and up-to-date knowledge to make appropriate decisions about CPR and communicate them effectively.

CPR should be performed competently and in accordance with current national and international guidelines. Local policies should be subject to scrutiny. Performance of CPR and the appropriateness and effectiveness of decisions about CPR should be the subject of continuous clinical audit. The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland and is open to all acute hospitals in England, Wales, Northern Ireland, and Scotland to join.

References

1 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:54.

2 NHS Executive. Resuscitation policy (HSC 2000/028). London: Department of Health; 2000.

3 Scottish Executive Health Department. Resuscitation policy (HDL (2000) 22). Edinburgh: Scottish Executive; 2000. NHS Scotland. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy. Edinburgh: Scottish Government; 2010. Available from: www.scotland.gov.uk/Resource/Doc/312784/0098903.pdf

4 NHS Wales. DNACPR Orders in the Primary Care Setting: Guidance notes to accompany the All-Wales DNACPR form; 2009. Available from: www.wales.nhs.uk/

5 Sandroni C, Nolan J, Cavallaro F, Antonelli M. In-hospital cardiac arrest: incidence, prognosis and possible measures to improve survival. *Intensive Car Med* 2007; 33:237-245.

6 Meaney PA, Nadkarni VM, Kern KB, Indik JH, Halperin HR, Berg RA. Rhythms and outcomes of adult in-hospital cardiac arrest. *Crit Care Med* 2010; 38:101-108.

7 Girotra S, Nallamothu BK, Spertus JA, Li Y, Krumholz HM, Chan PS for the American Heart Association. Trends in Survival after In-Hospital Cardiac Arrest. *N Engl J Med* 2012; 367:1912-1920.

8 Nolan JP, Soar J, Smith GB, Gwinnutt C, Parrott F, Power S *et al.* Incidence and outcome of in-hospital cardiac arrest in the United Kingdom National Cardiac Arrest Audit. *Resuscitation* 2014; 85:987-992.

9 Nolan J, Laver S, Welch C, Harrison D, Gupta V, Rowan K. Outcome following admission to UK intensive care units after cardiac arrest: a secondary analysis of the ICNARC Case Mix Programme Database. *Anaesthesia* 2007; 62:1207-1216.

10 Berdowski J, Berg RA, Tijssen JGP, Koster RW. Global incidences of out-of-hospital cardiac arrest and survival rates: Systematic review of 67 prospective studies. *Resuscitation* 2010; 81:1479-1487.

11 Perkins GD, Cooke MW. Variability in cardiac arrest survival: the NHS Ambulance Service Quality Indicators. *Emerg Med J* 2012; 29:3-5.

12 Resuscitation Council (UK), Royal College of Physicians of London, Royal College of Anaesthetists, Intensive Care Society, College of Emergency Medicine, Council for Professionals as Resuscitation Officers, Faculty of Intensive Care Medicine, Paediatric Intensive Care Society, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health, Royal College of Psychiatrists. Quality standards for cardiopulmonary resuscitation practice and training. London: Resuscitation Council (UK); 2013-2014. Available from: www.resus.org.uk

13 National End of Life Care Programme. Capacity, care planning and advance care planning in life limiting illness. A Guide for Health and Social Care Staff. Leicester: National End of Life Care Programme; 2011. Available from: www.ncpc.org.uk/freedownloads

14 Fritz Z, Malyon A, Frankau JM, Parker RA, Cohn S, Laroche CM, *et al.* The Universal Form of Treatment Options (UFTO) as an Alternative to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Orders: A Mixed Methods Evaluation of the Effects on Clinical Practice and Patient Care. *PLoS ONE* 2013; 8(9):e70977.

15 Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Russ L. Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). Bristol: Norah Fry Research Centre; 2013.

16 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822.

17 British Medical Association. The impact of the Human Rights Act 1998 on medical decision-making. London: BMA; 2007.

18 Tysiac v Poland [2007] 45 EHRR 42.

19 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:53.

20 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:54.

21 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:54 and 56.

22 British Medical Association. Withholding or withdrawing life-prolonging medical treatment (3rd ed). London: Blackwell Publishing; 2007.

23 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:54.

24 British Medical Association. Access to health records by patients. London: BMA; 2008.
25 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:65.
26 Aintree University Hospitals NHS Foundation Trust v James & Ors [2013] EWCA Civ 65.
27 Re R (Adult: Medical Treatment) [1996] 2 FLR 99.
28 General Medical Council (GMC). Treatment and care towards the end of life: good practice in decision making. London: GMC; 2010.
29 Department of Health. The NHS Constitution. London: The Stationery Office; 2013. Available from: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
30 McBrien M, Heyburn G. 'Do not attempt resuscitation' orders in the peri-operative period. *Anaesthesia* 2006; 61:625-627.
31 The Association of Anaesthetists of Great Britain and Ireland. Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period. London: AAGBI; 2009. Available from: www.aagbi.org/publications/publications-guidelines/A/F
32 See, for example: East Midlands ADRT Project Team. National ADRT Guide Appendix 1 [Internet]. Nottinghamnshire: East Midlands ADRT Project Team; 2012. Available from: www.adrt.nhs.uk/
33 Department for Constitutional Affairs. Mental Capacity Act 2005 Code of Practice. London: The Stationery Office; 2007.
34 The Scottish Government. Adults with Incapacity [Internet]. Edinburgh: Scottish Government; 2014. Available from: www.scotland.gov.uk/Topics/Justice/law/awi
35 British Medical Association. *Children and young people tool kit.* London: BMA; 2010. Available from: www.bma.org.uk/ethics
36 NHS Scotland. Resuscitation planning policy for children and young people (under 16 years) Children and Young People Acute Deterioration Management (CYPADM). Edinburgh: Scottish Government; 2010.
37 British Medical Association. Parental responsibility. London: BMA; 2008. Available from: www.bma.org.uk/ethics
38 British Medical Association. Children and young people tool kit. London: BMA; 2010. Available from: www.bma.org.uk/ethics
39 General Medical Council. 0-18 years: guidance for all doctors. London: GMC; 2007. para 51. Available from: www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp
40 General Medical Council. Treatment and care towards the end of life: good practice in decision making. London: GMC; 2010. 23 p.
41 R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822:65.
42 NHS Scotland. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland. Edinburgh: The Scottish Government; 2010.
43 General Medical Council. Treatment and care towards the end of life: good practice in decision making. London: GMC; 2010. para 77.
44 Nursing and Midwifery Council. The Code of Conduct – Professional standards for nurses and midwives. London: NMC; 2008. 5 p.
45 Nursing and Midwifery Council. Record keeping: Guidance for nurses and midwives. London: NMC; 2009. 5 p.
46 Association of Ambulance Chief Executives and Joint Royal Colleges Ambulance Liaison Committee (JRCALC). UK Ambulance Services Clinical Practice Guidelines. London: Class Professional Publishing; 2013.
47 National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Time to Intervene. London: NCEPOD; 2012. 9 and 45 p. Available from: www.ncepod.org.uk/2012cap.htm

Other published guidance

The British Medical Association publishes a wide range of relevant guidance, including:

- *Withholding and Withdrawing Life-prolonging Medical Treatment (third edition).* London: BMA, 2007.
- *Mental Capacity Act toolkit.* London: BMA, 2008.
- *Medical treatment for adults with incapacity, Guidance on ethical and medico-legal issues in Scotland.* London: BMA, 2009.

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Care Quality Commission. *Resuscitation: staffing.*
London: CQC, 2011.
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Joint Royal Colleges Ambulance Liaison Committee. *The UK Ambulance Service Clinical Practice Guidelines 2013.*
London: JRCALC, 2013.
The Association of Ambulance Chief Executives
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Internet: www.aace.org.uk

Leadership Alliance for the Care of Dying People (LACDP). *One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life.*
LACDP, 2014.
Internet: available at www.gov.uk

National Institute for Health and Care Excellence (NICE). *QS13 Quality standard for end of life care for adults.*
London: NICE, 2013.
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Internet: www.nice.org.uk

National Institute for Health Research
Do not attempt cardiopulmonary resuscitation (DNACPR) decisions
Project reference 12/5001/55
Publication due Autumn 2014
Internet: www.nets.nihr.ac.uk/projects/hsdr/12500155

NHS Health Scotland publishes a wide range of relevant guidance, including:

- *NHS Scotland Resuscitation Planning Policy for Children and Young People (under 16 years): Children and Young People Acute Deterioration Management (CYPADM).* Edinburgh: The Scottish Government, 2010.
- *NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation Indicators. Health Improvement Scotland.* Edinburgh: The Scottish Government, 2013.
- *Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland.* Edinburgh: The Scottish Government, 2010.

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NHS Improving Quality hosts a range of publications by the National End of Life Care Programme, which closed in 2013:

- *Capacity, Care Planning And Advance Care Planning In Life Limiting Illness: A guide for health and social care staff.* Leicester: National End of Life Care Programme, 2011.
- *DNACPR decisions: who decides and how?* Leicester: National End of Life Care Programme, 2012.

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The Resuscitation Council (UK) publishes a wide range of relevant guidance, including:

- *Quality standards for cardiopulmonary resuscitation practice and training.* London: Resuscitation Council (UK), 2013.
- *Resuscitation Guidelines 2010.* London: Resuscitation Council (UK), 2010.
- *Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions*. London: Resuscitation Council (UK), 2009.
- *Should Relatives Witness Resuscitation? A report from a Project Team of the Resuscitation Council (UK).* London: Resuscitation Council (UK), 1996 (archived but available on the Resuscitation Council (UK) website).

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