DNACPR Forms: April 2014 by Mike Stone (mhsatstokelib@yahoo.co.uk)

The place where all of the 'misunderstandings and unbalanced beliefs' around end-of-life, tend to come together, is in the DNACPR Form (sometimes called a DNACPR Order). There are enough problems with Advance Decisions (ADRTs), but a written ADRT is a legally-defined document: by contrast, a DNACPR Form is an 'operational document' and beyond its obvious objective, of preventing inappropriate attempted CPR, the answer to 'what exactly is a DNACPR Form ?' is complex.

I shall use the DNACPR Form pointed at by the Coventry & Warwickshire end-of-life website, here: I could have used a different form, but all in my opinion suffer from the same 'errors' to a very large extent. First I will look at the form and explain my issues with it - then I shall present a draft of a revised form, which in my mind fits the requirements of the law and of logic more correctly.

Fundamentally, the problem is that a written DNACPR Form, depending on its construction, content and signatories, can be three different things: a valid Advance Decision; a record of a clinical opinion that attempted CPR would necessarily be unsuccessful; or a record of a Mental Capacity Act 'best interests' decision.

These are three very different things.

Coventry & Warwickshire
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION
Adults aged 18 years and over

Name
Address
Date of birth
NHS or hospital number

Date of DNACPR order: / /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO
If "YES" go to box 2

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

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

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

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

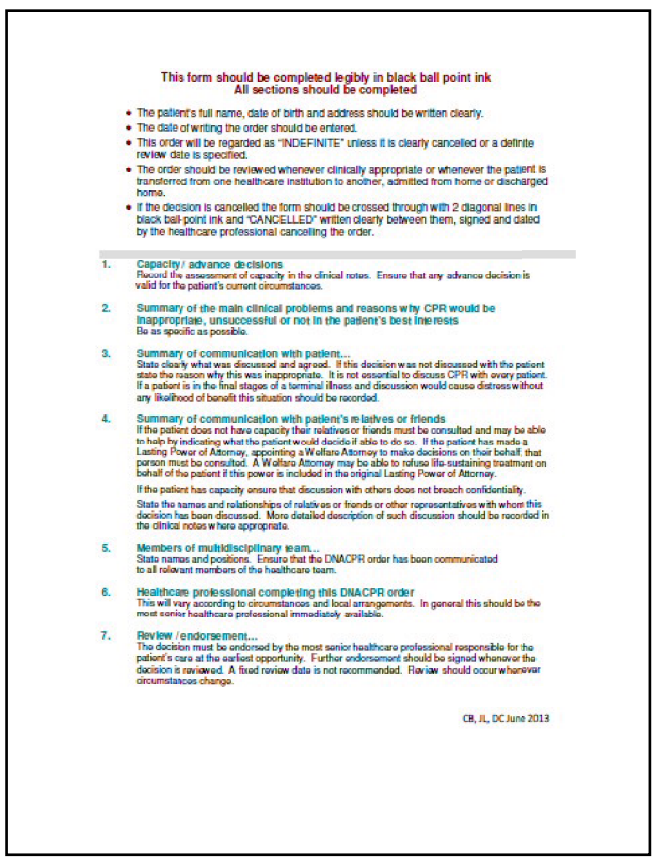
3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

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

6 Healthcare professional completing this DNACPR order:
Name Position
Signature Date Time

7 Review and endorsement by most senior health professional:
Signature Name Date
Review date (if appropriate)
Signature Name Date
Signature Name Date



This form should be completed legibly in black ball point ink
All sections should be completed

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

1. Capacity / advance decisions
Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient's current circumstances.

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

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

4. Summary of communication with patient's relatives or friends
If the patient does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity ensure that discussion with others does not breach confidentiality.

State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

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

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

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

CB, JL, DC June 2013

Clearly, the form needs to be linked to the patient.

Also, we are asked if the patient has mental capacity to make and communicate decisions about CPR (note the word 'communicate' - **not write down but communicate**): if lack of mental capacity is known to be the case, we are asked about Advance Decisions refusing CPR, and then about the possible existence of a Welfare Attorney.

However, we already have one mistake: this form is written in advance of a future CPA, as indeed is an ADRT refusing CPR - an ADRT is either valid or otherwise from the time of its creation ('valid' merely indicates things such as 'is witnessed', etc). However the applicability of an Advance Decision refusing CPR must be considered at the time that CPR is potentially provided - in other words, it is not the validity of an ADRT that is considered at the time of the CPA, but the applicability of the ADRT to the situation of the arrest (CPA). So it is fundamentally wrong to ask the question:

'are you aware of a valid Advance Decision refusing CPR which is relevant to the current condition'

It isn't '100% wrong' - it is possible that there is a 'stable condition, which if it persisted until a CPA, would fit the ADRT's criteria for applicability': but the 'reverse implication' (that somehow you can tell in advance of a future CPA, that the ADRT would not be applicable when that CPA occurred, is 100% wrong).

All you can be sure of before the CPA, is whether a written Advance Decision meets the limited criteria for validity.

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

Directly after checking for a welfare attorney, we are told the above: this actually introduces an interesting question about the meaning of the phrase 'best interests', which I discuss in a box on the next page. There is no question, that all DNACPR decisions, must comply with current law. There is, however, some debate about what that law actually is.

It seems clear, from the debate, that the law isn't entirely simple.

The Term ‘Best Interests’

The term ‘Best Interests’ is bandied about, without a consistent meaning: this is very unhelpful.

The first point, is that patients do not need to make decisions ‘in their own best interests’: mentally-capable patients, simply make and express their decisions, full stop.

The second point, is that ‘best interests’ is definitely the correct term for a decision made in compliance with section 4 of the Mental Capacity Act: but compliance with the Act, effectively means compliance with section 4(9), and section 4(9) requires a decision-maker to have ‘considered, and thought about, all of the things in section 4’. Although ‘perfect compliance’ isn‘t required by the Act, surely ’adequate compliance‘ is required for a best interests decision to satisfy the MCA - and one of the very strong guides in section 4, is ’the patient as a ‘thinking’ individual‘. In other words, any decision which could be made without ’consideration of what goes on inside the patient‘s own head’, appears to not correctly be a [MCA] ‘best interests’ decision.

For DNACPR, this seems to imply that ‘clinical DNACPR decisions’ (the ‘we will not offer CPR, because our [expert clinical] opinion is that attempted CPR would necessarily fail’) cannot be ‘best interests’ decisions: this doesn‘t necessarily mean that clinical DNACPRs are invalid, but it does mean they are nothing to do with the MCA’s ‘best interests requirement’.

It is also hard to argue that ‘reading a few notes in a crisis’ about DNACPR, recorded by other people who have ‘seriously worked through section 4 of the MCA, and arrived at their own DNACPR best interests decision(s)’, amounts to ‘considering section 4’: so, it is hard to argue that a DNACPR Form, can enable someone such as a 999 paramedic to ‘make’ a best interests DNACPR decision.

I have discussed this rather more clearly, in the post at 06/09/13 14:26 at:

http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?forumID=45&obj=viewThread&threadID=692

Boxes 2 to 4 (from the DNACPR Form) are shown below.

Box 2 is much too simple, and because it is clearly much too simple, the ‘purpose of reading the DNACPR Form’ is also conceptually flawed: see, for example, the box directly above, and my observation that it is logically indefensible to imply that the reader of a DNACPR Form ‘can then make a best interests decision (by ‘reader of a DNACPR Form’, I mean anyone who needs to read the form, to become informed: clearly anyone who already understands what the form records, is not, for these purposes, a ‘reader of the form’).

Box 3 summarises ‘communications’ - it is necessary to record communications, but **both sides** of the conversation should ideally sign to authenticate the record of a conversation.

Box 4 introduces the usual ‘distancing’ of relatives and friends from other involved people: in particular, box 3 is flawed if there is a Welfare Attorney with powers over CPR, and if there is a Welfare Attorney whose powers do not extend to CPR, then section 4(7) of the MCA seems to state that any decision maker should consult with both any Welfare Attorney (section 4(7)(c)) and anyone interested in the patient’s welfare (section 4(7)(b)).

2	**Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:**
3	**Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:**
4	**Summary of communication with patient's relatives or friends:**

Section 4(7) of the MCA seems to imply that almost everyone who is caring for, or who cares about, a mentally-incapable patient, should be consulted by any person who considers him/herself to be a section 4 decision-maker.

Clinical authors - **and this really isn’t excusable** - seem to read sections 4(7)(c) and 4(7)(d), but ignore section 4(7)(b).

It doesn’t easily fit anywhere in particular, so I shall discuss an aspect of box 3 here. Box 3, is seeking to record a justification for the ‘immediate MDT’ not informing the patient or a Welfare Attorney of a DNACPR decision: box 4 just asks for details of communication with relatives or friends.

Anyone who followed the media storm around the Liverpool Care Pathway, or media-reported complaints about CPR in hospitals in a wider context, will know that many patients and/or relatives, are **furious** when they learn of DNACPR decisions, which they were not told about.

While it might be upsetting to ‘tell a patient that CPR would no longer succeed’, there is also the question of ‘How can the patient obtain an independent second opinion about the likely success of CPR, if the immediate MDT does not tell the patient that they believe CPR could not be successful’.

This ‘not telling the laymen’ tends to move ‘disputes’ from ‘during the care’ to ‘post-mortem’ - I dislike that, intensely ! Among other things, it doesn’t help to promote the good communication and ongoing discussions that GOOD end-of-life care/behaviour requires.

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

6	**Healthcare professional completing this DNACPR order:**				
	Name		**Position**		
	Signature		**Date**	**Time**	

7	**Review and endorsement by most senior health professional:**				
	Signature		**Name**	**Date**	
	Review date (if appropriate)				
	Signature		**Name**	**Date**	
	Signature		**Name**	**Date**	

My problem with box 5, is [again] its concentration on the multidisciplinary team (MDT) - the wording 'contributed to' is also interesting, as it isn't the same as 'made the [decision]'.

My problem with box 6, is that this DNACPR Form assumes that a healthcare professional (HCP) will be 'completing' it: ditto with box 7, where we are told that the most senior HCP will be 'endorsing it' (if it is a record of the patient's refusal, 'endorse' isn't the right word: if a Welfare Attorney made a DNACPR best interests decision, the senior HCP does not 'endorse' the decision; if there is a valid written ADRT refusing CPR and the patient isn't mentally capable, the ADRT isn't 'endorsed' by anyone, let alone by the senior HCP).

In a nutshell, DNACPR decisions do not necessarily rest with either the senior HCP or indeed with the MDT - this form is too unclear about both 'process' and also 'authority' (especially, about authority).

1. Capacity / advance decisions
Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient's current circumstances.

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

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

4. Summary of communication with patient's relatives or friends
If the patient does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity ensure that discussion with others does not breach confidentiality.

State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

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

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

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

CB, JL, DC June 2013

Note 4 is good: it states that if the patient lacks mental capacity the relatives or friends MUST be consulted, and it explains why that is necessary (to try and work out 'what the patient would have decided, if the patient were able to decide').

This develops into a discussion of what lawyers call 'the substituted judgement test' - something I will not analyse here - but there is a fundamental issue with 'best interests' at present: HOW is the information gathered (about the clinical prognoses with and without the considered treatment, and 'informed views about the patient's likely [but unobtainable] choices') TURNED INTO an actual decision ? How are different 'factors' weighted, once available ?

Before I draft out my alternative version of a DNACPR Form, I need to consolidate matters by explaining where my own 'understanding' of the MCA, differs from 'the implied beliefs of the MCA's meaning' that can be inferred from clinical writings.

First: although clinicians accept that a suitably-empowered welfare attorney does (or, actually, could) be the person who makes section 4 best interests decisions about CPR (which amounts to forbidding attempted CPR when it might be clinically successful), I cannot see where the Act states that anyone else (except for a Judge) can 'impose' their own best interests decision. HCPs seem to believe that the senior HCP 'makes the best interests decision' but all the MCA actually requires, is that anybody who makes a best interests decision, has complied with 4(9).

This is complicated, by section 42 of the MCA - but section 42 in reality just makes things complicated, without changing the fact that if there isn't either a welfare attorney, or a court ruling, **then all the Act does is impose a legal duty** on decision-makers.

There is, I think, a way of 'thinking about things' that both fits the legal requirements of the MCA, also guides proper behaviour - see the box directly below.

One way of thinking about the MCA, is in terms of 'a requirement to anticipate future events'.

Doing that, you could reasonably argue that 'anyone caring for an already mentally-incapable patient, should be considering in advance what he/she would do, if some postulated future event happened (here, cardiac arrest): this would apply to anyone who might be 'with the patient' when a CPA occurred. This is logical, because anyone 'caring for/closely involved with' the patient, if faced with a situation where some decision were necessary, should 'be making it in the patient's best interests'.

This would be true of the nurses and doctors around the patient in a hospital, hospice or care home - but it would be equally true of the patient's 'family carers' if the patient were at home.

So deliberately depriving any carer - lay or professional - of 'the information necessary to make a 'good' decision, if faced with a decision to make', SEEMS VERY WRONG (whoever is withholding the necessary information).

Good EoL care and behaviour, requires TEAMWORK: not teamwork within an MDT, or within a family group, or within nursing staff or within medical staff - it requires GOOD TEAMWORK where EVERYONE 'CLOSELY SUPPORTING THE PATIENT' IS PART OF A **SINGLE UNIFIED TEAM**.

It is worth exploring what clinical authors write about 'consensus'.

The GMC's end-of-life guidance, proposed as containing the principles which should be followed by the team considering what is to replace the Liverpool Care Pathway, is:

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

http://www.gmc-uk.org/static/documents/content/End_of_life_9_May_2013.pdf

Sections 47 and 48 cover disagreements about 'best interests'.

Resolving disagreements

47 You should aim to reach a consensus about what treatment and care would be of overall benefit to a patient who lacks capacity. Disagreements may arise between you and those close to the patient, or between you and members of the healthcare team, or between the healthcare team and those close to the patient. Depending on the seriousness of any disagreement, it is usually possible to resolve it; for example, by involving an independent advocate, seeking advice from a more experienced colleague, obtaining a second opinion, holding a case conference, or using local mediation services. In working towards a consensus, you should take into account the different decision-making roles and authority of those you consult, and the legal framework for resolving disagreements.

48 If, having taken these steps, there is still significant disagreement, you should seek legal advice on applying to the appropriate statutory body for review (Scotland) or appropriate court for an independent ruling.22 The patient, those authorised to act for them and those close to them should be informed, as early as possible, of any decision to start such proceedings, so that they have the opportunity to participate or be represented.

Section 47 mentions 'in working towards a consensus' (so clearly the GMC 'likes a consensus to be reached') and section 48 mentions applying for a court ruling to resolve disputes.

My local region's EoL guidance has got a flow chart by Tracy Redgate:

http://www.c-a-s-t-l-e.org.uk/media/13079/best-interests_capacity-flow-diagram3-may2013.pdf

It also leads to 'if there is no consensus, you might need to apply for a court ruling'.

If there is a disagreement about what is in a person's best interests this should be addressed locally but ultimately if all other means to resolve the dispute have failed the Court of Protection might need to rule on the person's best interests.

What clinically-authored guidance never seems to do, in my experience, is to point out what I myself have pointed out at:

http://www.bmj.com/content/347/bmj.f4085/rr/654490

If there is a consensus, then there is NOT an identifiable decision-maker: clinical guidance seems to imply that [in the absence of a welfare attorney with powers over CPR] the senior clinicians 'makes the best interests decision about CPR' after consultation with other people - this idea that the senior clinician 'makes the decision' is both undermined if resolution via court might be necessary, and isn't logically necessary anyway if there is a consensus [unanimous] decision.

There is a fundamental conceptual difference here - I consider that 2) is correct if there isn't a welfare attorney with powers over CPR:

1) The senior clinician, after consultation with other professionals and with the family and friends of the patient, makes the best interests decision about CPR;

OR (only one of these can be true - either 1, or as I claim, 2)

2) The senior clinician, and other professionals when necessary, and the family and friends of the patient discuss CPR, and if everyone agrees that either 'attempt CPR' or 'do not attempt CPR' is the correct 'best interests decision', then a best interests decision about CPR has been arrived at.

The 'conceptual difference' between 1) and 2), is that if you consider 1) to be correct [legally], then it does not foster a fully-inclusive attitude re 'the family and friends' - but if you believe that 2) is legally true, then it effectively **enforces** an 'attitude of integration' between the professionals and the laymen. Or, at any rate, it forces the clinicians to try to achieve that integration.

It **isn't** 'the clinicians consult with the family and friends, and then the clinicians make the best interests decision'.

It **isn't** 'the family and friends consult with the clinicians, and then the family and friends make the best interests decision'.

It **is** 'Everyone gets together, thinks about the best interests decision, and if everyone is in agreement, then there is a best interests decision but there is not an identifiable decision-maker'.

Although clinical DNACPRs are only different in terms of communication, between the situation of a mentally-capable or mentally-incapable patient, and of course best interests decisions do not really come into play if a patient has a cardiopulmonary arrest (CPA) directly from mental capacity (I discuss this, right), there are significant differences between 'CPA from earlier mental incapacity', and 'CPA from mental capacity'.

A written Advance Decision refusing CPR, is to cover the possible situation of mental incapacity intervening **before** the patient could explain the ADRT to his clinicians: **once explained, the [verbal] explanation of the written ADRT, 'carries the instruction'**.

Cardiopulmonary Arrest from Mental Capacity

The issue here, is up-to-date information about the patient's refusal/acceptance of CPR. Even if the patient had written an ADRT refusing CPR, at any time until the CPA occurs, the patient can have [verbally] retracted such a written ADRT - even for life-sustaining treatments, the retraction of an ADRT can be verbal. This implies that whatever has previously been recorded about the patient's decisions about CPR, anyone who was physically with the patient 'just before' the CPA, must be asked 'has he changed his mind, or expressed any recent decision, about CPR, which has not yet been recorded ?'.

This is very problematic for patients who arrest at home, unless paramedics/etc are told to believe what family carers tell them: it is also problematic, if clinicians [wrongly] believe that 'a verbal refusal of CPR is not (can never be) legally binding'.

Cardiopulmonary Arrest from Mental Incapacity

The issue here, is what something such as a written ADRT refusing CPR, 'was actually intended to convey by way of its instruction'. The instruction (the ADRT) cannot be retracted by the patient any longer, but there might be disagreement about exactly what the ADRT 'means' - there is a particular problem with the simplest of all ADRTs refusing CPR: the only entirely unambiguous ADRT is the 'I refuse CPR whatever caused my heart to stop beating, full stop' one, but unfortunately clinicians will not [so far] publish specimen wording which all clinicians accept will mean that.

However, as the mental incapacity occurred before the CPA, in this situation there is time for clinicians and family and friends to discuss what should happen if a future CPA occurs - that might, or might not, lead to the desirable situation of consensus emerging, but it is a different problem from the 'arrest from capacity' situation

It should now be possible, to define ‘the problems to be addressed’ by DNACPR Forms.

However, I do not consider that a single type of form, can satisfactorily cover both an arrest directly from mental capacity, and an arrest subsequent to a period of mental capacity: the reason is that in the former, the only legitimate refusal of potentially successful CPR must come from the patient, whereas for the latter legitimate reasons to withhold potentially successful CPR could be a legacy (and therefore ‘fixed’) refusal from the patient, a [best interests] decision made by a welfare attorney, or a best interests decision made by someone else.

So, I shall first look at the design of a DNACPR Form for the situation of a patient who lost mental capacity at an earlier time than the CPA being considered - I will call this ‘pre-existing mental incapacity’. The legitimisation for DNACPR can therefore be one of:

A properly-understood refusal of future CPR which was expressed by the patient before the patient lost mental capacity;

A best interests DNACPR decision made by a welfare attorney;

A best interests DNACPR decision made when there is not a welfare attorney;

CPR is not offered because it is believed that it would fail;

The person who is in a position to attempt CPR, does not attempt CPR because of ‘something mentioned above’.

DNACPR Form

THIS FORM IS ONLY TO BE USED FOR PATIENTS WHO ARE KNOWN TO LACK MENTAL CAPACITY AT THE TIME THE FORM IS BEING WRITTEN UP.

SECTION 1 Patient Identifier

This section identifies the patient - this section is not controversial, and I will not bother to fill-in the required details.

SECTION 2 Confirmation of Mental Incapacity

The clinician/clinicians who are stating that the patient lacks the mental capacity to make decisions about CPR, **must** sign below.:

Name of Clinician Clinical Position Signature Date Reviewed on

.....

.....

COMMENT: this is only ‘a rough draft’ or ‘elaboration of concept’: ‘Date’ indicates the time of first creation of the form, and ‘reviewed on’ indicates a subsequent ‘review’ date(s).

The form continues on the next page.

SECTION 3 Is There a Written Advance Decision Refusing CPR ?

Is there a written ADRT refusing CPR YES ☐ NO ☐ (tick one)

If 'yes' then indicate the location of the ADRT:

If 'yes' then are the patient's clinical team and family and/or friends, in agreement about the instruction [regarding whether the refusal is of CPR whatever causes a CPA, or whether the refusal 'has qualifying circumstances'] or not ?

YES ☐ NO ☐ (tick one)

If 'yes', and the clinical team and the patient's family/friends/family carers are in consensus agreement about the instruction the patient intended to indicate when the Advance Decision was completed, then the instruction (the refusal) should be clearly explained below, and then at least one clinician, **and also** at least one of the family/friends, should sign to confirm this agreed understanding of the ADRT's instruction

The Refusal of CPR applies, in the opinion of the HCPs and the family/friends:

1) Whatever caused the CPA, and however likely or unlikely an arrest was considered to be Tick to confirm this is the case ☐

2) (TO BE COMPLETED **ONLY** IF THE REFUSAL OF CPR IS CONDITIONAL):

The refusal of CPR applies if ...
...
...
...
...
...
...

Name of Clinician	Clinical Position	Signature	Date
.....			
.....			
.....			

Name of Family/Friend	Relationship To Patient	Signature	Date
.....			
.....			
.....			

The form continues on the next page.

SECTION 4 The DNACPR Decision was made by a Welfare Attorney

This first section is to be completed by at least one clinician (preferably by/including the senior clinician), who must sign it. The second section is to be completed by the Welfare Attorney(s) who made the DNACPR decision.

I confirm that I have seen a registered Lasting Power of Attorney which gives the Welfare Attorneys listed below powers over CPR:

Name(s) of (ALL) Welfare Attorney(s)

.....
.....
.....

Name of clinician(s) Clinical Position Signature

.....
.....

I (or all attorneys unanimously) are satisfied either that the patient while still mentally capable expressed [and did not subsequently retract] a clear refusal of future CPR, OR else I/we have properly considered the Mental Capacity Act's best interests requirements and I (or all attorneys unanimously) have decided that DNACPR is in the patient's best interests.

The Refusal of CPR applies:

1) Whatever caused the CPA, and however likely or unlikely an arrest was considered to be Tick to confirm this is the case ☐

2) (TO BE COMPLETED **ONLY** IF THE REFUSAL OF CPR IS CONDITIONAL):

The refusal of CPR applies if ...

...
...
...
...
...
...

Name of Welfare Attorney Signature Date

.....
.....
.....

The form continues on the next page.

SECTION 5 DNACPR Decision NOT made by a Welfare Attorney but made when CPR might be clinically successful

The senior clinician should sign below, along with [ideally] all of those 'close to the patient' ('family and friends') who it was possible to involve (and who indicated that they felt sufficiently-connected to the patient to legitimately be involved in best interests decision-making) in best interests decision-making about CPR. If a less senior clinician signs, then the senior clinician should also sign later. If at least one of the 'family and friends' who was involved in best interests decision making has not signed, the clinicians should explain the reason for this in the box provided.

We the undersigned hereby confirm that after discussions between the Multi-Disciplinary Team and the patient's Family, Friends and others who could legitimately contribute to the decision, there is unanimous agreement that DNACPR is, in our opinion, in the patient's best interests. In particular, we confirm that to the best of our knowledge, none of the patient's family/friends are objecting to the DNACPR decision.

The Best Interests DNACPR decision applies:

1) Whatever caused the CPA, and however likely or unlikely an arrest was considered to be Tick to confirm this is the case ☐

2) (TO BE COMPLETED **ONLY** IF THE REFUSAL OF CPR IS CONDITIONAL):

The refusal of CPR applies if ...
...
...
...

Name Role or relationship Signature Date
.....
.....
.....
.....
.....
.....

MUST BE COMPLETED IF **NO** FAMILY/FRIEND HAS SIGNED ABOVE: The reason no family/friend has signed is

Name and signature of clinician who explained this: NAME SIGNATURE

All of the signatories above hope that less-involved clinicians, such as 999 Paramedics, will be guided by our [more-holistically-informed] decision as described here.

The form continues on the next page.

SECTION 6 DNACPR Recommendation on the grounds that the patient's clinical condition would render attempted CPR INEVITABLY unsuccessful

A suitably-senior clinician (ideally the most senior involved clinician) is of the opinion that any attempt at CPR, should any arrest occur for whatever reason, would inevitably be unsuccessful because of the pre-existing clinical situation of the patient.

The clinician(s) must explain the clinical condition which would inevitably make attempted CPR unsuccessful below, and must also sign below.

Details of the clinical condition(s) which would cause CPR to fail:

.....
.....
.....

Name of clinician(s) Clinical Position Signature Date

.....
.....

List of those persons involved in the patient's care in an ongoing manner

The persons who have signed below, are involved with the patient and with each other (as part of the group of people supporting the patient) in an ongoing manner: please assume that any of these individuals are probably 'up-to-date' with developments (especially where records are incomplete, unclear, or potentially not up-to-date for some reason):

Name Relationship or Role Signature Date

.....
.....
.....
.....
.....
.....

NOTE: if any of the listed persons is no longer an integral part of the patient's close-support-team, the person will strike through their name above and initial that, or at least two of the remaining persons will do that where the person 'removing him/herself' cannot physically de-list him/herself.

Form to be used while the patient is still mentally capable

DNACPR Form

THIS FORM IS ONLY TO BE USED FOR PATIENTS WHO ARE MENTALLY CAPABLE AT THE TIME THE FORM IS BEING WRITTEN UP.

SECTION 1 Patient Identifier

This section identifies the patient - this section is not controversial, and I will not bother to fill-in the required details.

SECTION 2 The Patient has created a written Advance Decision which Refuses future CPR

The patient has created what appears to the undersigned to be a valid Advance Decision (ADRT) refusing CPR, and this can be found at:

Location of the written ADRT refusing CPR:

The patient has also discussed what he intended to convey by means of the wording on the ADRT (in other words, he has talked to the following people and made clear any ambiguity or lack of clarity which might occur to a reader) with the following persons, and they and he have signed to confirm that discussion has taken place:

Name of Person Position or Relationship Signature Patient's Signature

.....
.....
.....
.....
.....

NOTE: while the patient retains mental capacity, he/she can retract the ADRT at any time, and such a retraction can be verbal.

The form continues on the following page.

SECTION 3 The Patient has expressed a clear refusal of CPR but has NOT created a written ADRT

The patient has made it entirely clear that he/she is refusing future CPR, to the persons supporting the patient and who are listed (and who have signed to confirm this) below, but verbally.

The nature of the refusal, in the understanding of the undersigned, is:

(explain here, any conditionality the patient has expressed in his refusal of future CPR)

We the undersigned, agree that the patient has verbally-expressed a refusal of CPR, and in our opinion the refusal is correctly described by the wording we have inserted above:

Name of Person Position or Relationship Signature Date

.....
.....
.....
.....
.....

WE HAVE SUGGESTED THAT THE PATIENT CREATES A WRITTEN ADRT BUT THE PATIENT HAS NOT YET DONE THIS TO THE BEST OF OUR KNOWLEDGE - if we can suggest why the patient has not created a written ADRT, our opinion(s) would be:

Because the patient has clearly-expressed this refusal of CPR DIRECTLY TO US, we who have signed above will be treating this refusal as legally-binding on US (unless the patient retracts the refusal at a future time).

The form continues on the following page.

SECTION4 DNACPR Recommendation on the grounds that the patient's clinical condition would render attempted CPR INEVITABLY unsuccessful

A suitably-senior clinician (ideally the most senior involved clinician) is of the opinion that any attempt at CPR, should any arrest occur for whatever reason, would inevitably be unsuccessful because of the pre-existing clinical situation of the patient.

The clinician(s) must explain the clinical condition which would inevitably make attempted CPR unsuccessful below, and must also sign below.

Details of the clinical condition(s) which would cause CPR to fail:

.....
.....
.....

Name of clinician(s) Clinical Position Signature Date

.....
.....

List of any Welfare Attorneys under a Registered Lasting Power of Attorney

The persons listed below are Welfare Attorneys who, if the patient loses mental capacity, will then have decision-making powers over CPR. The clinician(s) who sign below, have seen the LPA documentation.

Name of Welfare Attorney Signature of WA (if WA is available to sign here)

.....
.....
.....
.....
.....
.....

Name, role and signature of clinician(s) who have inspected the Lasting Power of Attorney

Name of Clinician Position Signature

.....
.....

The form continues on the following page.

List of those persons involved in the patient's care in an ongoing manner

The persons who have signed below, are involved with the patient and with each other (as part of the group of people supporting the patient) in an ongoing manner: please assume that any of these individuals are probably 'up-to-date' with developments (especially where records are incomplete, unclear, or potentially not up-to-date for some reason):

Name Relationship or Role Signature Date

.....
.....
.....
.....
.....

NOTE: if any of the listed persons is no longer an integral part of the patient's close-support-team, the person will strike through their name above and initial that, or at least two of the remaining persons will do that where the person 'removing him/herself' cannot physically de-list him/herself.

Closing Comments:

I would direct any reader who has doubts about section 3 on page 11 (in other words, doubts about the 'legal validity' of a verbal refusal of CPR), to my post at 11/04/13 13:32 in the series at:

http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?obj=viewThread&threadID=665&forumID=45

I would also, on a more general theme, direct the reader to my post at 15/03/14 15:32 (in other words, to 'poser no 8' in a series) and the PDF which can be down-loaded from the link, both of which describe my Core Care Team concept for end-of-life care/behaviour, at:

http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?forumID=45&obj=viewThread&threadID=692

Author: Mike Stone Contact mhsatstokelib@yahoo.co.uk