Whatever happened to Section 7.29 of the MCA Code of Practice ?

A survey of hospital trusts about an aspect of their DNACPR Forms, autumn 2014

7.29 Attorneys must always follow the Act's principles and make decisions in the donor's best interests. If healthcare staff disagree with the attorney's assessment of best interests, they should discuss the case with other medical experts and/or get a formal second opinion. Then they should discuss the matter further with the attorney. If they cannot settle the disagreement, they can apply to the Court of Protection (see paragraphs 7.45–7.49 below). While the court is coming to a decision, healthcare staff can give life-sustaining treatment to prolong the donor's life or stop their condition getting worse.

See sections 6(6) and 6(7) of the Mental Capacity Act, for the source of the Code's interpretation above: **it is entirely clear**, that the role of a suitably-empowered welfare attorney is to **make** [section 4 MCA] best interests decisions.

Foreword

For reasons which are not relevant, I have read the Broadmoor Savile report: I found it a hugely depressing report, because it seemed to me that most of the people mentioned in it, were **not** 'working towards a common good'.

I get very angry, and perplexed, when I read a lot of clinically-authored material about end-of-life and the Mental Capacity Act, but I have no doubt that most of these clinicians **are** well-intentioned: the problems I see in their writings, seem to stem from other issues, quite often 'perspective'.

But good intentions, are not enough: **good, and fairly balanced, outcomes, should be the objective for end-of-life** – and the current guidance, does not achieve that, especially for EoL home deaths. And as allowing more patients to die at home is an objective of the healthcare system at present, this isn't satisfactory.

I have previously sent some questions to England's Clinical Commissioning Groups, in order to highlight some problems with written Advance Decisions, and with post-mortem behaviour for home EoL deaths: the survey was written up in my 'One England, One Law' piece. This is the write-up of a question I have more recently sent to many of England's hospital trusts, asking about a detail of their DNACPR Forms: the e-mail containing the question, can be found at the end of the Introduction to this report, and the responses I received form the final section of this report. The question about DNACPR Forms, highlights the issue of 'decision-making authority' – in fact, it highlights one of the very few places where the law is both very clear, and also where it is provable that clinical behaviour is definitely not in line with the law.

By sheer coincidence, it turns out that an updated version of the 'Joint CPR Guidance' (the BMA/RCN/RC(UK) guidance)

www.resus.org.uk/pages/dnacpr.htm

was published while I was still collecting responses from the hospital trusts: this will allow me to quote the new Joint CPR Guidance here, and to quote the responses detailed in this report, in my comments to the BMA/RCN/RC(UK) about its new CPR guidance,

Mike Stone

mhsatstokelib@yahoo.co.uk

Introduction

It seems to me, that there is a significant difference between the way I look at the Mental Capacity Act, and the [apparent] way that many clinicians look at it. In essence, to me the Act is about the definition of, and duties and powers of, decision-makers, and about the principles these decision-makers must follow: it is clear that the Act is not describing clinical things, such as the best way to apply a treatment, or how best to arrive at a prognosis - the Act is about a wider, less well-defined and much more complex, question of should an intervention take place at all. I also see what I consider to be a lack of terminological clarity, around the phrase 'best interests': I reserve 'best interests' for decisions which involve the decision-maker being able to claim to have legitimately complied with section 4(9) of the MCA - effectively, this places the non-offer of a medical intervention because it could not be clinically successful, and any decision made by a person who does not understand at least a substantial portion of the things described in section 4 of the MCA, as 'not best interests decisions' (although, that does not automatically equate to not legitimate decisions).

By contrast, many clinical authors devote much more time to descriptions of the clinical situations in which decisions are made, with much less discussion of the origin of the 'legal authority or legal justification' of the person making a decision.

Very bluntly, and somewhat over-simplified, I analyse the 'rules' by defining the decision-making process and this leads to less involvement of precise clinical situations in my analyses: most clinical authors are much more precise in their categorisations of clinical situations, but then they tend to make unproven assertions about who can legitimately be a decision-maker.

In its most concise form, this difference comes down to sentences which I often see, such as 'ultimately DNACPR is a clinical decision': unless 'a clinical decision' need **not** be a decision which requires a clinician to make it, that sentence is clearly wrong, because of sections 6(6) and 6(7) of the MCA, taken in logical combination with the absence of any requirement that welfare attorneys and court deputies need to be clinically qualified.

As I am examining a fairly simple issue in this report, I will number the pages (except for the final section, which shows the responses I received from hospital trusts, where the individual responses are numbered), but I will not be indexing it.

The question I sent to hospital trusts, along with the e-mail addresses to which the question was sent by e-mail, is shown on the next two pages.

3

Saturday, 20 September, 2014 14:33

From: "michael stone" <mhsatstokelib@yahoo.co.uk> To: customerservice@aintree.nhs.uk PALS@bhrhospitals.nhs.uk barnsleypals@nhs.net communications@bedfordhospital.nhs.uk communications@bfwhospitals.nhs.uk pals@rbh.nhs.uk comments@bthft.nhs.uk communications@bsuh.nhs.uk pals@addenbrookes.nhs.uk pals@cmft.nhs.uk corporate.affairs@chs.northy.nhs.uk information@cddft.nhs.uk dhft.contactpals@nhs.net headquarters@dchft.nhs.uk ehn-tr.pals@nhs.net ekh-tr.generalenquiries@nhs.net contact@elht.nhs.uk enquiries@esht.nhs.uk pals@ghnt.nhs.uk enquiries@geh.nhs.uk customer.service@gwh.nhs.uk communications@gstt.nhs.uk enquiries@hhft.nhs.uk pals.hey@hey.nhs.uk advice.complaints@ipswichhospital.nhs.uk kch-tr.PALS@nhs.net enquiries@kingstonhospital.nhs.uk patient.relations@leedsth.nhs.uk Lisa.Gurrell@lhch.nhs.uk info@ldh.nhs.uk mtwpals@nhs.net communications@meht.nhs.uk advicecentre@midstaffs.nhs.uk PALS@midyorks.nhs.uk communications@nnuh.nhs.uk complaints@nbt.nhs.uk pals@ngh.nhs.uk contactus@northumbria.nhs.uk nuhcommunications@nuh.nhs.uk PALSJR@ouh.nhs.uk plh-tr.PALS@nhs.net pals@porthosp.nhs.uk rde-tr.Pals@nhs.net PALS@rlbuht.nhs.uk enquiries@srft.nhs.uk PST@sth.nhs.uk Chris.Morgan@stft.nhs.uk pals@swft.nhs.uk communications@dgh.nhs.uk foundation.office@nuth.nhs.uk rwh-tr.PALS@nhs.net communications@uhb.nhs.uk patientsupportservices@uhs.nhs.uk pils.complaints.compliments@uhl-tr.nhs.uk pals.service@wmuh.nhs.uk wih-tr.communications@nhs.net enquiries@york.nhs.uk

Dear Sir or Madam,

Assuming that your trust provides ‘general’ hospital services for adults, would you please forward this e-mail to your hospital's Director of Nursing for me (if you have more than one such hospital, with different DoNs, please forward to each),

Regards, Mike Stone

Dear Director of Nursing,

There seems to be something legally flawed/anomalous, about contemporary DNACPR Forms, and I am sending this e-mail to a selection of hospitals, to try and be more certain of this. Nurses are the most appropriate HCPs for this issue, viewed 'in general terms'.

I assume that your hospital has got a DNACPR Form (using the term, to include any standardised record of DNACPR status). As CPR is essentially no different from any other [life sustaining] treatment, the justifications for withholding CPR are (ignoring any 'cost issues'):

1) the patient has refused the intervention;

2) the intervention could not be clinically effective;

3) the intervention is being withheld as the result of a Mental Capacity Act best interests decision.

All DNACPR Forms, seem to include those 3 justifications - and many forms, record the existence of welfare attorneys (i.e. of 'LPAs').

However, I have not yet seen a DNACPR Form, which EXPLICITLY provides for the signature of a welfare attorney as the justification for a best interests DNACPR decision INSTEAD OF the signature of the 'senior clinician'.

This is legally confused, at best: if I appoint someone as my welfare attorney, and give my attorney powers over life-sustaining treatments including CPR, then it is the attorney who has the legal authority to 'make' best interests decisions about CPR - and the attorney's decision is not 'validated' by anyone else (so the senior clinician does not somehow 'validate' a DNACPR best interests decision, which was made by a suitably-empowered welfare attorney). The law is very clear indeed, on this point.

So my question, is does your hospital's DNACPR Form, make it clear that if a best interests DNACPR decision was made by a suitably-empowered welfare attorney, that the decision is not somehow 'authorised' by your clinicians ?

Regards, Mike Stone

PS There are more complicated issues around 'best interests' - but this one, is entirely unambiguous (although court deputies have no powers over life-sustaining treatments, anyway):

MCA section 6(6)

Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by—
(a) a donee of a lasting power of attorney granted by P, or
(b) a deputy appointed for P by the court.

PPS This is part of a 'wider discussion' I am engaged in, about various end-of-life, MCA and related issues - the absence of the signature of welfare attorneys on contemporary DNACPR Forms, is very revealing of 'clinical thinking which departs from the law'.

5

Analysis of the Responses and my Comments

I am in the position of being able to point to many of my 'analytical pieces' on the web, and I will do that to save mere reproduction here. But before I move on, I wish to point to a PDF which can be downloaded from the link which follows - although it does not cover everything, it includes a 'DNACPR Justification Hierarchy' which I consider to be correct, and most of my analysis of DNACPR behaviour, stems from that justification hierarchy:

http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?forumID=45&obj=viewThread&threadID=741

There is an issue, which affects the debate about DNACPR behaviour, and where I differ from many clinicians: in essence, it hinges on the question of 'futile CPR' - I see the extension beyond 'CPR would not re-start the heart' into 'or it would only temporarily extend life' as very undesirable, because it involves a factor (quality of life) which correctly falls within 'MCA best interests' as opposed to clinical expertise. I have discussed this at:

http://www.bmj.com/content/348/bmj.g4094/rr/702748

I wrote in that piece:

> But there are many issues: I am only happy with 'clinical DNACPRs' if the term means 'attempted CPR would definitely not restart the heart'. But many clinicians wish to add 'or would be futile', with 'would be futile' meaning 'or would only restart the heart for a few hours or days'. How, objectively, is that 'few' to be decided: an hour, a day, 3 days or what ?

That apart, during the summer of 2014 I sent two questions to England's Clinical Commissioning Groups, and wrote the replies up as 'One England One Law'. I demonstrated from the responses, that written a Advance Decision forbidding CPR is unlikely to work satisfactorily for patients who are at home, because of the way that 999 paramedics behave at present.

It also turns out, that there is a conceptual issue with verbal refusals of CPR (many clinicians believe that a verbal refusal of CPR 'is not legally binding') and also a complication around what I shall term 'record keeping and evidence'. The 'verbal refusal' point is something I have explained at 11/04/13 13:32 in the series of posts at:

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

The recently-revised version of the Joint CPR Guidance also states (no 8 on page 4):

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.

That is logically - and necessarily legally ! - correct: written ADRTs are for situations where a patient is unable to discuss his/her refusal with the clinical team and others who are supporting the patient.

It is also clearly stated as part of the first flowchart in response no 8 - which correctly explains the top-three justifications for withholding clinically-possible CPR as being, in this order:

1 A direct refusal of CPR from a mentally-capable patient;

2 A valid and applicable written Advance Decision refusing CPR;

3 A DNACPR best interests decision which is expressed by a suitably-empowered welfare attorney (or by all welfare attorneys if there are several).

The next justification down, is a section 4 best-interests decision which is made by someone who is not a welfare attorney: those decisions do not genuinely carry any legal authority, although section 42 of the MCA allows for the decisions made by a senior clinician to carry a sort of 'operational authority' in directing the behaviour of more junior clinicians.

However, what is clear, is that refusals from the patient, are DECISIONS - and so are best interests decisions (irrespective of whether those decisions can be imposed on others). By contrast, if even the world's foremost clinical expert on the clinical aspects of CPR, stated that 'CPR could never be successful for this patient, because of his pre-existing clinical situation', that is an OPINION.

Clinicians typically describe 'clinical DNACPRs' (the 'in my opinion, CPR couldn't work' one) as decisions, and typically this 'decision' is recorded as being made by the senior clinician. If the justification for a DNACPR Form, was that in the opinion of the senior clinician CPR could not be successful, would you find it perverse if that senior clinician said 'but I've explained that to the patient's daughter, and she is going to sign the DNACPR Form instead of me' ? So. assuming that your answer is 'that would be very strange indeed', exactly the same thing must be true of response no 3:

If a LPOWA indicates a DNACPR order is suitable, the form is completed by the medical staff indicating that a best decision interest has been made and that the patient has a LPOWA. The form is signed by the medical staff. There is currently no space for a LPOWA to sign the form.

Welfare Attorneys do NOT 'indicate that a DNACPR order is suitable' - **the welfare attorney makes the decision**.

Even for an unexpected arrest, if a suitably-empowered welfare attorney is present, the attorney is empowered to make the DNACPR decision - as Response no 7 has correctly pointed out:

In the event of an unexpected cardiac arrest, CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless:

a PWA who has the authority to make the decision is present at the point of the arrest. This individual will then make the decision regarding discontinuation of CPR

Unfortunately, Response no 7 is still at the very least, 'less than clear' about the legal position of a verbal refusal of CPR (which is somewhat intricate - but, I have already dealt with that).

Response no 8, consisted of a set of policy documents, and the flowchart in one was spot-on, whereas the flowchart in another was truly 'weird' - the flowchart in response no 8 with the straw-coloured text boxes contains this chain:

Is there a valid ADRT ? ... if yes .... Incorporate into TEP form
or Best Interests Decision

Now, a written ADRT is valid or invalid, from the moment of its creation (validity involves things such as 'is witnessed'): its applicability must in principle be considered by whomever is considering treatent at the time of the arrest (for an ADRT refusing CPR) - what must be considered re applicability, is essentially section 25(4) of the MCA.

But the idea that a valid ADRT can be 'part of a best interests decision' is weird: if the ADRT is applicable, it is followed instead of any best interests decision being made (section 5(4) of the MCA - so section 1(5) of the Act, is in fact incorrect: this is a point which is well-understood, and not 'controversial'). An ADRT which is not applicable - i.e. fails the test of section 25(4) - might perhaps be sufficiently close to being applicable, as to strongly guide a best interests decision: similarly, a written ADRT which is invalid for a technical reason, but which if valid would be applicable, might also strongly guide a best interests decision. But, those concepts are sufficiently subtle, as to make the flowchart as it appears, 'dubious in the extreme'.

Especially, as the next section of the flowchart, goes:

Is there a Personal welfare Lasting Power of Attorney (PW-LPA) registered with the Office of the Public Guardian? ... if yes ... Ensure that the PW-LPA is consulted and incorporated in any decisions regarding TEP

This seems to imply that welfare attorneys who are empowered to make best interests decisions, are being consulted during decision-making, when legally the attorney is the person who is doing the consulting: **it is possible, that some people are being confused by section 4(7) of the Act** (a welfare attorney whose decision-making authority does not extend over the decision being made, must be consulted by any other best interests decision maker: but clearly a welfare attorney who is making te decision, is not required to 'consult himself').

Response no 9 states:

The Resuscitation Council UK in line with the Mental Capacity Act (code of practice) is very clear that neither patients with capacity, relatives, welfare attorneys, nor deputies can demand treatment that is clinically inappropriate. The final decision is therefore a clinical decision, which is why a clinician signs the form, not an attorney.
Guidance for this can be found on the Resuscitation Council UK website which refers to the issues you have raised.

I have never been impressed by the Resuscitation Council UK's understanding of the law: it simply isn't true 'that the final decision is [therefore] a clinical decision'.

As welfare attorneys can 'impose their DNACPR decision on everyone else [unless a court ruling is applied for to challenge the decision]' and welfare attorneys are probably laymen, whatever a section 4 best interests DNACPR decision is, it ISN'T 'a clinical decision'.

This also confuses a treatment not being offered because it would be unsuccessful, with a potentially-successful treatment being withheld - two very different 'concepts'.

There are remaining issues, about who assesses the 'acceptability of the risks associated with a treatment' - I have discussed this online:

http://www.bmj.com/content/349/bmj.g4349/rr/759994

While I am pointing at my online pieces, although the issue of 'clinicial confidentiality versus section 4(6)' as not part of my question, it will almost inevitably crop up in CPR policies - I would say that it isn't as simple as most clinicians believe it to be, and I would point people at section 3(4)(b) of the MCA:

http://www.bmj.com/content/348/bmj.g4094/rr/703333

Response no 9 also tells us:

We have a Trust process for ensuring that the methods used for determining and recording a patient's mental capacity are robust, and we audit this assessment process for patients with a TEP form. The compliance is then reported to the Trust's Integrated Safeguarding Committee who monitors the performance.

I am actually, mainly interested in sorting out professional behaviour for patients who are End-of-Life (I prefer the term Last Year(s) of Life, which is being used in parts of London, as it happens) and who are in their own homes: my issues, hinge on how exactly live-with relatives, 'fit in'. Which in my opinion, should be 'fully, with the sole limitation, that they are not experts on clinical factors'. That isn't what happens, at present.

If you stop writing belief and behaviour sets, which are hugely offensive to live-with relatives, and which also tend to thwart patient self-determination, then you come up with something very different (a behaviour set which I term 'the Core Care Team') - that cannot be made to 'fit with' mainstream ideas about 'robustness', 'safeguarding' and 'primacy of records'. **But it definitely makes more sense** - the approaches which can be successfully used within hospitals and hospices, simply 'defy balanced logic' if you try to apply them to the situation of patients who are in their own homes.

Again, Response no 1 is hugely muddled, about who posssesses legal authority:

The Trust's form – copy attached- does not make explicit provision for a welfare attorney or relative to sign the form, nor does it provide for a competent patient to do so. A written report from an IMCA or any formally appointed other welfare attorney on best interests would be filed in the patient's case notes, and a summary of discussions would be recorded by medical staff in the normal way in the case notes.

This, again, seems to imply that if a welfare attorney makes a DNACPR decision, that this is somehow 'guiding a decision then made by the clinical team' - it isn't !

Closing Comments

Any reader who has got this far, will doubtless have understood that I sent the question to hospitals, not because I am particularly interested in DNACPR Forms, but because I believe that contemporary end-of-life behaviour is currently flawed.

My suggestion for improvement, is best understood by reading a piece I called More Conversation Less Confusion - that piece is not online, so if you want it, send me an e-mail. There is a downloadable PDF (mainly extracted from MCLC) covering just the Core Care Team which can be downloaded from a link in 'Poser no 8' at:

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

My survey of CCGs was written up as One England One Law, and this also is not available online - again, if you want to read it, send me an e-mail.

My fundamental objection to 'current clinical interpretation/understanding' of the MCA, is that section 4 imposes a legal duty, not a legal power - if you accept that as what the Act states, you can hardly avoid the correctness of the argument I presented at:

http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?forumID=45&obj=viewThread&threadID=732

http://www.bmj.com/content/348/bmj.g2043/rr/700882

The webpage from which the new version of the Joint CPR Guidance can be downloaded, includes this wording:

In particular, the new edition:

emphasises the importance of making anticipatory decisions about CPR as an integral part of good clinical practice: leaving people in the ‘default’ position of receiving CPR should they die, regardless of their views and wishes, denies them of the opportunity to refuse treatment that for many may offer no benefit and that many may not want;

once again emphasises that every anticipatory decision about CPR must be based on assessment of the person’s individual circumstances at that time;

emphasises the importance of involving people (or their representatives if they are unable to make decisions for themselves) in the decision-making process; this often involves a person making a shared decision with their healthcare professionals, but where CPR has no realistic chance of success it may involve informing people of the decision and explaining the basis for it;

emphasises that when CPR has no realistic chance of success it is important to make decisions when they are needed, and not to delay a decision because a person is not well enough to have it explained to them or because their family or other representatives are not available;

nevertheless a clear plan should be made to explain and discuss the decision with the person and/or their representatives at the earliest practicable opportunity;

emphasises that, whenever possible, anticipatory decisions about CPR are best made well in advance, when people are well enough and have enough time to consider them carefully and discuss them fully with anyone that they wish to, including their family and members of their healthcare team;

emphasises the increasing recognition that such advance decisions are often best made as part of a broader consideration of the type of care or treatments a person would wish to receive (as well as the type of care or treatments they would not wish to receive) should their health deteriorate so that they are unable to make choices for themselves;

emphasises the importance of careful documentation and effective communication of anticipatory decisions about CPR.

I have a dislike of the term 'shared decision-making':

http://www.bmj.com/content/349/bmj.g4855/rr/761712

but I have made the text larger for two sections of that wording above, because they are stressing the undesirability of making decisions 'in a crisis', and also point towards what I would describe as 'an inclusive and collaborative attitude', while seemingly accepting that if they are able to, patients make their own choices.

These are all things I keep 'banging on about' - along with the fact that the family members, and others who are similarly involved, when a loved-one is dying, are neither 'volunteers' nor 'passive bystanders'.

Until clinicians accept that patients elaborate their own decisions while they are able to do that, and it should not matter whether a patient explains a decision to a layman or to a clinician, and that if patients cannot make their own decisions, everyone close to the patient should be working together to try and arrive at the best possible decision, I will probably continue 'to bang on at HCPs about these issues'.

Everyone 'closely surrounding' a Last Year(s) of Life patient, is usually trying to do their best to support the patient: the clinicians understand the clinical factors, the family and friends understand 'what dad would decide, if he can't decide himself', nobody is very keen to start 'the hard conversations' and consequently almost everyone tends to be working with less information than would be present 'in idealised models/protocols', which potentially confuses things enormously (especially for LYoL at home).

Perspective issues are problematic: for example, when thinking about written ADRTs, paramedics see section 26(2) as 'writ large' while I see section 25(4)(c) as 'writ large'.

But it is surely madness, to 'let the tail wag the dog' by failing to base belief and behaviour sets, around the idea that normally the laymen and the clinicians, are trying to row the boat in the same direction - the direction, of 'helping the patient'.

This cannot be inproved, especially for LYoL at home, by stressing things such as EPaCCS, 'robust [records-based] safguarding' and the differences between the laymen and the HCPs who are supporting the patient - it needs a change of 'attitude' towards genuine collaboration and inclusivity,

Mike Stone October 2014

Contact: mhsatstokelib@yahoo.co.uk

The Responses I received from Hospital Trusts

The complete e-mail which was sent out, is shown as part of the Introduction – but the essential question it contained, was simply:

So my question, is does your hospital's DNACPR Form, make it clear that if a best interests DNACPR decision was made by a suitably-empowered welfare attorney, that the decision is not somehow 'authorised' by your clinicians ?

Any direct answers to the question, are shown below.

In some cases one or more 'policy document' and/or DNACPR Form was sent either with, or instead of, the answer. I have not included these, although where particularly relevant, I have included extracts from them – I do need to be 'complete' for this survey to reveal the strangeness of a situation when if it is legally clear that 'best interests' DNACPR decision-making authority resides in a welfare attorney, it is not the welfare attorney who signs a DNACPR Form which is a record of that decision !

Response no 1

The Trust's form – copy attached- does not make explicit provision for a welfare attorney or relative to sign the form, nor does it provide for a competent patient to do so. A written report from an IMCA or any formally appointed other welfare attorney on best interests would be filed in the patient's case notes, and a summary of discussions would be recorded by medical staff in the normal way in the case notes.

Response no 2

This was a response, but using some form of 'secure delivery system' with terms and conditions of use, which I was not prepared to sign up to: therefore, I'm not sure what the response was.

Response no 3

You asked whether the Trust's DNACPR forms make it clear that if a best interests DNACPR decision was made by a suitably-empowered welfare attorney, that the decision is not somehow 'authorised' by the clinicians. If a LPOWA indicates a DNACPR order is suitable, the form is completed by the medical staff indicating that a best decision interest has been made and that the patient has a LPOWA. The form is signed by the medical staff. There is currently no space for a LPOWA to sign the form. Attached is a copy of the form that is used by this Trust. This is a regional form and is used throughout hospital and community in the (local area – redacted).

Response no 4

No, if the decision is discussed with a welfare attorney then this needs to be stated on the DNACPR form. There is space for the doctor to write a summary of the discussion. However the DNACPR needs to be signed by a senior doctor and countersigned by a consultant to be valid. There is currently no space for the welfare attorney to sign the form.

Response no 5

Does your hospital's DNACPR Form, make it clear that if a best interests DNACPR decision was made by a suitably-empowered welfare attorney, that the decision is not somehow 'authorised' by your clinicians ?

No, the form does not. The form asks for evidence of the validity of the power of attorney and also states they must be consulted about the decision. However, the DNACPR form must be signed by the appropriate clinician.

Response no 6

Further to your request for information dated 20 September 2014, I understand that we do not have a specific DNACPR Form.

Response no 7

This hospital sent me a policy document, as opposed to an answer: three interesting sections from the policy are:

2.2 Please note if there is clear evidence of a recent verbal refusal of CPR whilst the person had capacity then this should be carefully considered when making a best interests decision.
Good practice means that the verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make an ADRT to ensure the verbal refusal is adhered to.

5.8 Lasting Power of Attorney (LPA): The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to make a LPA by appointing a Personal Welfare Attorney (PWA) who can make decisions regarding health and wellbeing on their behalf once capacity is lost.

8.2 In the event of an unexpected cardiac arrest, CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless:

☐ a valid DNACPR decision or an ADRT is in place and made known

☐ a PWA who has the authority to make the decision is present at the point of the arrest. This individual will then make the decision regarding discontinuation of CPR

☐ there is clear evidence of a recent verbal refusal of CPR as this needs to be considered when making a best interests decision.

Response no 8

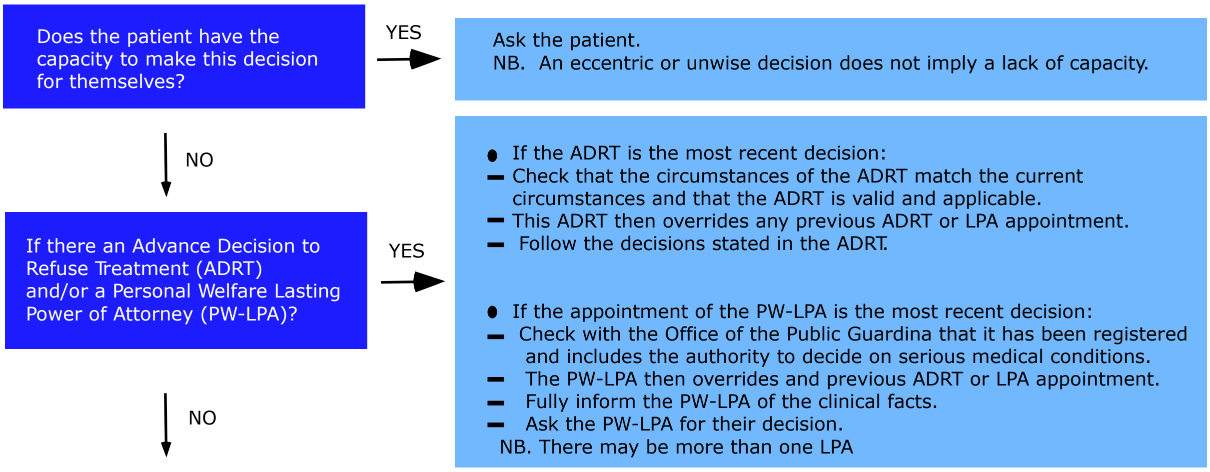
You asked:
Does your hospital's DNACPR form, make it clear that if a best interests DNACPR decision was made by a suitably-empowered welfare attorney, that the decision is not somehow 'authorised' by your clinicians ?

We use the Treatment Escalation Plan (TEP) for discussing and recording decisions re resuscitation. We have a Resuscitation Decision policy which guides clinicians in decisions – TEP also has guidance re decisions.

The TEP is [region redacted] wide and we work with partner organisations in the development, evaluation and training for this

Please find the attached PDF documents that support decision making.

There were 4 'TEP' documents attached, and one included a flowchart from which I have extracted the following:



Does the patient have the capacity to make this decision for themselves?

Ask the patient.
NB. An eccentric or unwise decision does not imply a lack of capacity.

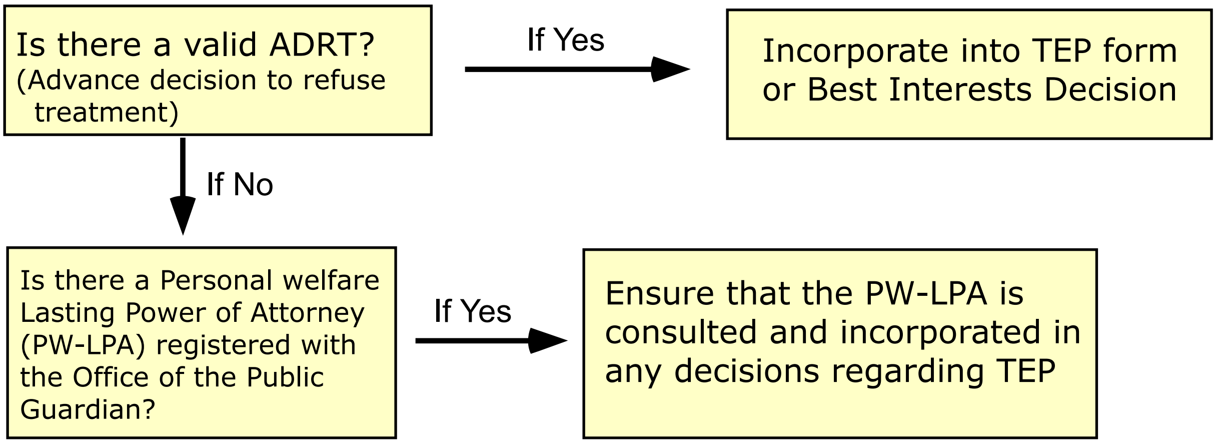
If there an Advance Decision to Refuse Treatment (ADRT) and/or a Personal Welfare Lasting Power of Attorney (PW-LPA)?

- If the ADRT is the most recent decision:
  - Check that the circumstances of the ADRT match the current circumstances and that the ADRT is valid and applicable.
  - This ADRT then overrides any previous ADRT or LPA appointment.
  - Follow the decisions stated in the ADRT.
- If the appointment of the PW-LPA is the most recent decision:
  - Check with the Office of the Public Guardina that it has been registered and includes the authority to decide on serious medical conditions.
  - The PW-LPA then overrides and previous ADRT or LPA appointment.
  - Fully inform the PW-LPA of the clinical facts.
  - Ask the PW-LPA for their decision.

NB. There may be more than one LPA

I have no quibbles with that - although I think (I'm not sure) that the documentation appointing a welfare attorney will probably bear an official seal, and also will describe the extent of the attorney's powers.

However, the same set of 'TEP' documents, included another document from which I have extracted part of a flowchart on the following page:



Response no 9

Within the [redacted] NHS Foundation Trust we use the Treatment Escalation Plan and Resuscitation Decision Record (TEP) (attached) to record resuscitation decisions. This form is used [area redacted]-wide and the decisions on the TEP form are the responsibility of the individual patient's senior clinician.

In normal practice, the clinician will discuss resuscitation status with a patient who has capacity or with relatives, an Independent Mental Capacity Advocate (IMCA), or welfare attorney if the patient does not have capacity. The TEP form has specific sections to record who has had these discussions and their content, including any previous wishes made by the patient.

We have a Trust process for ensuring that the methods used for determining and recording a patient‘s mental capacity are robust, and we audit this assessment process for patients with a TEP form. The compliance is then reported to the Trust's Integrated Safeguarding Committee who monitors the performance.

The Resuscitation Council UK in line with the Mental Capacity Act (code of practice) is very clear that neither patients with capacity, relatives, welfare attorneys, nor deputies can demand treatment that is clinically inappropriate. The final decision is therefore a clinical decision, which is why a clinician signs the form, not an attorney. Guidance for this can be found on the Resuscitation Council UK website which refers to the issues you have raised.

Response no 10

Further to your request under the Freedom of Information Act 2000 dated 23rd September 2014, I can confirm that the Trust holds the information requested which is disclosed below. The text of your request is repeated in *italics*, followed by our response:

Does your hospital's DNACPR form, make it clear that if a best interests DNACPR decision was made by a suitably-empowered welfare attorney, that the decision is *not somehow “authorised” by your clinicians?*

Do not attempt CPR decisions at [a London hospital redacted] NHS Foundation Trust are made using a computerised form that is part of patient’s electronic patient record (EPR). There is no physical signature on the form but the details of the doctor completing the document are recorded by the EPR system when they log in.

The form contains sections to identify if the patient is capable of participating in decisions about CPR and, if they are not, if they have identified a Welfare Attorney or made an advance decision under the Mental Capability Act.

There are also sections on the form to record summaries of discussions with Welfare Attorneys and to identify members of the multidisciplinary team who were involved in the decision making.

There is no specific part of the form that asks for a Welfare Attorney to assent to the order.