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Health and Community Services

Jersey Multi-agency Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) 16 years and over Policy

February 2021

DOCUMENT PROFILE

Document Registration	HCS-PP-CG-0002-09
Document Purpose	Policy / Procedure / Guideline / Strategy
Short Title	Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) 16 years and over Policy
Author	Dr Sarah Whiteman
Publication Date	February 2021
Target Audience	All Health and Social Care staff working for organisations signed up to the policy
Circulation List	HSSD, FNHC, SoJAS, All GPs and practices, Care & Residential Homes
Description	Description of the multi-agency approach agreed with respect to 'do not attempt resuscitation' issues
Linked Policies	Multi-Agency Capacity Policy (SPB)
Approval Route	Hospital Care Quality Group / Community Care Quality Group / Integrated Governance Committee
Review Date	Feb 2023
Contact Details	PCGT@health.gov.je

CONTENTS LIST:

1. Introduction

1.1 The purpose of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should a person suffer cardiac arrest.

This policy must BE read in conjunction with the Capacity and Self-Determination (Jersey) Law 2016 https://www.jerseylaw.je/laws/enacted/Pages/L-30-2016.aspx.

Although cardiopulmonary resuscitation (CPR) can be attempted on any person, there are times when it is not reasonable to do this. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision.

1.2 Scope (Who, Where & When)

This policy applies to all of the multidisciplinary health, social and tertiary care teams involved in person care across the range of settings within the States of Jersey.

This policy is applicable to all people aged 16 years and over.

This policy should be read in conjunction with the HCS Advance decision to refuse treatment policy and guidelines and should work in conjunction with end of life care planning for people.

1.3 Principles (Beliefs)

The Jersey Unified DNACPR policy will ensure the following:

1. All people are presumed to be “for CPR” unless:

    - a valid DNACPR decision has been made and documented or;
    - a valid and applicable Advance Decision known in law as an Advance Decision to Refuse Treatment (ADRT) prohibits CPR.
    - or other reasons as below

2. 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 interest’s 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.

3. There will be some persons for whom attempting CPR is inappropriate; for example, a person who is clinically assessed to be at the end of life. In these circumstances it is unlikely that CPR would not restart the heart and breathing

of the person and should therefore not be attempted. The person and/or relatives/carers should be informed of this.

4. All DNACPR decisions are based on current legislation and guidance.

5. In persons with long-term conditions, where it is expected that there is a chance of success of CPR, then the person should be asked whether they would wish it to be performed. The person may ask for family or friends to be involved in the decision.

6. If the person lacks capacity to take part in the discussion and make decisions then the relatives or recognised carers should be asked if the person had previously made their wishes about resuscitation known. The Capacity and Self-Determination (Jersey) Law 2016 and associated code of practice provides information on assessing capacity and undertaking best interest determinations for people who lack capacity. . All discussion and subsequent decisions should be accurately and clearly documented. Persons, family or friends have a right to refuse to take part in the discussions.

7. A standardised Island wide form for people aged 16 years and over for DNACPR decisions will be used.

8. Effective communication concerning the person's resuscitation status should occur among all members of the multidisciplinary healthcare team involved in their care and across the range of care settings. This should include carers and relatives where appropriate, via documented verbal or written discussions.

9. The DNACPR decision-making process will be measured, monitored and evaluated to ensure a robust governance framework.

10. Training at a local/regional level will be available to enable staff to meet the requirements of this policy. Each organisation will be responsible for its quality assurance arrangements.

11. This policy has been reviewed by the States of Jersey Law Officers' Department, legal advisers to ensure it provides a robust framework underpinned by relevant national guidance and legislation. However, this policy does not constitute legal advice. Advice should be sought on specific issues where circumstances so dictate. Organisations may also wish to ensure the policy is reviewed by their local legal services.

2. Policy Purpose

This policy will provide a framework to ensure that DNACPR decisions:

- respect the wishes of the person, where possible
- reflect the best interests of the person
- provide benefits which are not outweighed by burden.

This policy will provide clear guidance for health and social care staff.

This policy will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the person's care or treatment options.

3. Corporate Procedure

LEGISLATION AND GUIDANCE

Legislation/Policy

3.1 Health and social care staff are expected to understand how the Multi-Agency, Capacity policy works in practice and the implications for each person for whom a DNACPR decision has been made.

3.2 The following provisions of the Human Rights (Jersey) Law 2000 are relevant to this policy:

- the person's right to life (Article 2 under Schedule 1)
- to be free from inhuman or degrading treatment (Article 3 under Schedule 1)
- respect for privacy and family life (Article 8 under Schedule 1)
- freedom of expression, which includes the right to hold opinions and receive information (article 10 under Schedule 1)
- to be free from discriminatory practices in respect to those rights (Article 14 under Schedule).

. Guidance

The Resuscitation Council (UK):

Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision) https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Quality Standards for Cardiopulmonary Resuscitation practice and training (2015) Resuscitation Council (UK), available at https://www.resus.org.uk/quality-standards/acute-care-quality-standards-for-cpr/#prevention

Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest. A report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). 2012, available at http://www.ncepod.org.uk/

4. Roles and Responsibilities

4.1 This policy and its forms/appendices apply to all health and social care staff working within signatory organisations including primary, secondary, independent, ambulance and voluntary. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed privately by any agency who are signatories to the policy.

4.2 The decision to complete a DNACPR form should be made by a Consultant, General Practitioner or other Doctor who has been delegated the responsibility by their employer. In addition, a can make a decision to complete a DNACPR. Organisations must ensure that a DNACPR decision is verified by a professional with overall responsibility at the earliest opportunity. Nurses are not currently allowed to make DNACPR decisions in Jersey. Within the Health and Social Services department if the Consultant or GP are not available then a designated deputy may make a decision. These are a specialist possessing the relevant Royal College Fellowship or Membership, a staff grade Doctor or Associate Specialist nominated by the Consultant.

4.3 Health and social care staff should encourage the person or their representative, where able, to inform those looking after them that there is a valid documented DNACPR decision and where this can be found, in order to follow a unified approach to storage of information in the home setting.

4.4 The Chief Executive (equivalent or representative) of each organisation is responsible for:

- ensuring that this policy adheres to statutory requirements and professional guidance
- supporting unified policy development and the implementation in their organisations
- ensuring that the adherence to the policy is monitored
- reviewing the policy, form and supporting documentation regularly
- compliance, both clinical and legal with the local policy and procedure
- ensuring that the policy is agreed and monitored by the organisation’s governance process.

4.5 Directors or Managers responsible for the delivery of care must ensure that:

- staff are aware of the policy and how to access it
- the policy is implemented
- staff understand the importance of issues regarding DNACPR
- staff are trained and updated in managing DNACPR decisions
- adherence to the policy is audited and the audit details are fed back to a nominated Director
- DNACPR forms, leaflets and policy are available as required.

4.6 Consultants/General Practitioners/other Doctors making DNACPR decisions must:

- verify any decision made by a delegated professional at the earliest opportunity
- ensure the decision is properly documented
- involve the person, follow best practice guidelines when making a decision and, if appropriate, involve other relevant people in the discussion
- communicate the decision to other health and social care providers
- review the decision if necessary.

4.7 Health and social care staff delivering care must:

- adhere to the policy and procedure
- notify their line manager of any training needs
- sensitively enquire about existence of a DNACPR decision and/or an Advance Decision to refuse treatment. An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision a person can make now to refuse a specific type of treatment at some time in the future.
- check the validity and applicability of any decision
- notify other services of the DNACPR decision as required and when the person's care is transferred
- participate in the audit process.

4.8 Ambulance staff must ensure they adhere to the policy including relevant organisational policies, procedures and guidance.

4.9 Provider organisations must ensure:

- that commissioned services implement and adhere to the policy and procedure as per local contracts
- that pharmacists, dentists and others in similar health and social care occupations are aware of this policy
- that DNACPR education and training is available and provided. This should be the subject of regular audit
- audit of provider organisations' compliance with regional DNACPR paperwork, record of decision making, and any complaints/clinical incidents involving the policy.

5. Process

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

- a valid DNACPR decision or an Advance Decision to Refuse Treatment is in place and made known
- there is clear evidence of a recent verbal refusal of CPR (expressed by a person with capacity at that time) as this needs to be considered when making a best interest's decision.

The clinician responsible at the time makes the decision that CPR is not appropriate for other justifiable reasons.

5.2 In the event of registered health care staff finding a person with no signs of life and clear clinical signs of prolonged death, and with no DNACPR decision or an Advance Decision to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR, mindful of the need to be trained in 'recognition of life extinct' (ROLE). Ambulance Staff should follow current policy and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Consideration of the following will help to form a decision, based on their professional judgement which can be justified and later documented:

- what is the likely expected outcome of undertaking CPR?
- is the undertaking of CPR contravening the Human Rights (Jersey) Law 2000.
- is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interests decision on behalf of the person
- Provided the registered health care staff member has demonstrated a rationale for their decision-making, the employing organisation will support the member of staff if this decision is challenged.
- In hospital where death has occurred without a person receiving CPR or without a valid DNACPR order, the lead Resuscitation Officer should be informed.

5.3 The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

- where the person's condition indicates that effective CPR is unlikely to be successful
- when CPR is likely to be followed by a length and quality of life not acceptable to the person
- where CPR is not in accord with the recorded, sustained wishes of the person who is deemed mentally competent or who has a valid applicable Advanced Decision to Refuse Treatment (ADRT)

5.4 The decision-making framework is illustrated in Diagram 1. When considering making a DNACPR decision for a person it is important to consider the following:

- is cardiac arrest a clear possibility for this person? If not, this policy will probably not apply
- if cardiac arrest is a clear possibility for the person, and CPR may be successful, will it be followed by a length and quality of life that would not be of overall benefit to the person? The person's views and wishes in this situation are essential and must be respected. If the person lacks capacity a best interest determination should be made. The Consultant or GP will seek the views of those interested in the welfare of the person.
- The person should be informed of the DNACPR decision unless they will clearly be harmed by this information; in which case the rationale for not discussing it should be fully documented in the medical notes.

Decision - making framework

Is cardiac or respiratory arrest a clear possibility for the patient?

NO → It is not necessary to discuss CPR with the patient unless they express a wish to discuss it. There is a presumption in favour of attempted resuscitation

YES

Is there a realistic chance that CPR could be successful?

NO → If a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it. Those close to the patient should also be informed and offered explanation, unless a patient's wish for confidentiality prevents this. Where a patient lacks capacity, the decision should be explained to those close to the patient without delay. If this is not done immediately the reasons why it was not practicable or appropriate must be documented. If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

Where a patient lacks capacity and has an attorney or court appointed delegate, with authority for health and welfare matters, this representative should be informed of the decision not to attempt CPR and the reasons for it, as part of the ongoing discussion about the patient's care.

YES

Does the patient lack capacity to make CPR decision **AND** have an advance decision to refuse treatment (ADRT) specifically refusing CPR **OR** have an appointed attorney or delegate for health and welfare?

YES → If a patient has made an ADRT refusing CPR, and the criteria for applicability and validity are met, this must be respected.
If an attorney or delegate has been appointed for health and welfare they should be advised of the ADRT, if not already aware.

NO

Does the patient lack capacity to make CPR decision?

YES → The patient's past and present wishes and feelings should guide decision-making. When a patient cannot share their wishes, check records to see if the patient has already had their wishes and feelings documented. Where wishes and feelings are not known, consultation with those close to the patient should be used in a best interest determination.

NO

Is the patient willing to discuss his/her wishes regarding CPR?

NO → Respect and document their refusal. Discussion with those close to the patient may be used to guide a decision in the patient's best interests, unless confidentiality restrictions prevent this.

YES

The patient must be involved in deciding whether or not CPR will be attempted in the event of a cardiorespiratory arrest.

If cardiorespiratory arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting CPR.

- Anticipatory decisions about CPR are an important part of high quality health care for people at risk of death or cardiorespiratory arrest.
- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.
- Decisions about CPR require sensitive and effective communication with patients and those close to patients.
- Decisions about CPR must be documented fully and carefully.
- Decisions should be reviewed with appropriate frequency and when circumstances change.
- Advice should be sought if there is uncertainty.

Adapted from: Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. 3rd edition (1st revision) 2016

5.5 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:

- the DNACPR decision is made following discussion with person/others, this must be documented in their notes
- the DNACPR decision has been made and there has been no discussion with the person because they have indicated a clear desire to avoid this. If you conclude that the person does not wish to know about or discuss the DNACPR decision, you should seek their agreement to share with those close to them, with carers and with others, the information they may need to know in order to support the person's treatment and care
- if a discussion with a person with capacity, regarding DNACPR is deemed inappropriate by medical staff, this must be clearly documented and displayed prominently in their notes
- the DNACPR information leaflet should be made available where appropriate to people and their relatives or carers. It is the responsibility of individual organisations to ensure that different formats and languages can be made available
- the DNACPR decision is required for a person who lacks capacity to assist in the decision-making process. This decision must be discussed with friends/family if confidentiality allows and their views taken into consideration when making a best interest decision. For those who have no one to consult with an Independent Capacity Advocate (ICA) referral can be considered.

6. Documenting and communicating the decision

6.1 Once the decision has been made, it must be recorded on the Standard approved Jersey Form:

- document the decision in the medical notes, if applicable state clearly what was discussed and agreed with the person or health proxy and;
- the decision must then be reviewed by the most senior healthcare professional responsible for the person's care within a reasonable clinical timeframe.

6.2 A copy of the form should stay with the person at all times (Appendix 1)

- The person's full name, clinical reference number, date of birth, date of writing decision and institution name should be completed and written clearly. Address may change due to person's deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address
- In an inpatient environment e.g. hospitals, Specialist Palliative Care in-patient units, a copy of the form stays together in the front of the person's notes until death or discharge.

On discharge (from the care setting instigating the form):

- A copy of the form should be given to the person
- A copy remains in the medical notes
- A copy is retained for audit purposes: on person discharge the third copy of the triplicate DNACPR form must be sent to the Resuscitation Officer for audit purposes. • For deceased people – 2 copies stay in medical notes and one copy is retained for audit purposes i.e. on person death the third copy of the triplicate DNACPR form to be sent to the Resuscitation Officer for audit purposes. This is the responsibility of the Ward Clerk

6.3 For people in their homes:

- One copy of the form is placed in their home
- One copy remains in their notes at the GP's surgery via an upload to EMIS. Practices must ensure that the DNACPR decision is recorded in the person's electronic problem list using the appropriate Read Code.
- One copy is retained for audit purposes. The audit will rely on access to the original copy of the DNACPR form and to GP electronic records within the Community
- Where 'message in a bottle' schemes exist, the tear-off slip on the form may be completed and placed in the "message in a bottle" in the person's refrigerator. The location of the DNACPR form needs to be clearly stated on the tear off slip e.g. "My form is located in the nursing notes in the top drawer of the sideboard in the dining room." If a "message in a bottle" is not available, a system must be put in place to ensure effective communication of the DNACPR forms location to all relevant parties including the ambulance service. It is therefore the responsibility of the clinician issuing the DNACPR form to ensure all relevant staff/other parties are made aware of the decision and the location of the form.
- Some people may choose to wear an alert bracelet or necklace signposting the relevant information and in the future electronic, barcode or other technologies may assist.

6.4 Where the form has been initiated in another institution these forms will be honoured island-wide and their on-going validity confirmed. The Digital Care Strategy is likely to result in the use of electronic DNACPR forms in future. Users should ensure that all relevant parties remain informed.

6.5 Confidentiality: If the person has the capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by a person with capacity to allow information to be disclosed to family or friends must be respected. Where people lack capacity, and their views on involving family and friends are not known, health and social care staff may disclose confidential information to people close to them where this

is necessary to discuss the person's care and is not contrary to their interests.

6.6 Doctor and Nurses caring for the person have responsibility to ensure communication of the DNACPR decision to other healthcare professionals. The use of an end of life care register is recommended to ensure effective system-wide communication of the decision. It is recommended where the person remains at home, the ambulance service is informed.

7. Discharge/Transfer Process

7.1 Prior to discharge, the person, or relevant other if the person lacks capacity, MUST be informed of the decision unless it is felt that such a discussion would cause physical or psychological harm. Any such discussion should be undertaken with sensitivity involving the person and those close to the person where possible.

7.2 If such discussion is likely to cause the patient a degree of harms then it is usually not possible to place a DNACPR form in the person's home until further discussions have taken place.

7.3 When transferring the person between settings all staff involved in the transfer of care of a person need to ensure that:

- the receiving institution is informed of the DNACPR decision
- where appropriate, the person (or those close to the person if they lack capacity) has been informed of the DNACPR decision

Ambulance transfer: If discussion has taken place regarding deterioration during transfer the 'Other Important Information' section must be completed by any health care staff, stating; the preferred destination (this cannot be a public place), the name and telephone number of next of kin or named contact person. If there are no details and the person is being transferred, should they die, Recognition of Life Extinct (ROLE) will be performed by a paramedic and the deceased person will be taken to the Hospital Mortuary by Ambulance. The decision will be communicated to the organisation where the patient was collected from. It is the department's responsibility to inform other organisations/relatives as appropriate

Non ambulance transfer: Other organisations transferring persons between departments, other healthcare settings and home should be informed of, and abide by, the DNACPR decision.

7.4 Current discharge letters must include information regarding this decision. If the DNACPR decision has a review date it is mandatory that the discharging doctor speaks to the GP to inform them of the need for a review. This should be followed up with a discharge letter.

7.5 Cross Boundaries: If a person is discharged from an institution that does not use the Jersey Unified DNACPR form, providing their form is agreed following clear governance and legal process, it will be recognised by health and social care staff, who will confirm its ongoing validity.

8. DNACPR

8.1 DNACPR decisions will be regarded as 'indefinite' unless:

- a definite review date is specified
- changes in person's condition would require a person review by the responsible clinician
- the person's expressed wishes change.

If a review date is specified then the Doctor with overall responsibility (or a delegated representative) must contact all relevant on-going care givers to inform them of the need for a review. This contact must initially be by phone/in person and then followed up with a discharge letter to ensure that the details of the review are clear to all concerned. Informal reviews can take place at any time.

8.2 It is important to note that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, each time that a DNACPR decision is reviewed, the reviewer must consider whether the person can contribute to the decision-making process. It is not usually necessary to discuss CPR with the person each time the decision is reviewed, if they were involved in the initial decision. Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

9. Situation where there is lack of agreement regarding DNACPR decisions

9.1 A person with capacity may refuse CPR for any reason. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the person, and possibly their relatives. In these circumstances they should be encouraged to write an Advance Decision to Refuse Treatment (ADRT). A DNACPR decision is made and recorded to guide the decisions and actions of those present should the person suffer cardiac arrest but is not a legally binding document. An ADRT is a legally binding document that the person has drawn up (when they had capacity to make decisions) and in which they have stipulated certain treatments that they would not wish to receive, and the circumstances in which those decisions would apply.

9.2 Please note if the person had capacity prior to arrest, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. 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 or DNACPR to ensure the verbal refusal is adhered to.

9.3 People may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, a person can refuse to hold a DNACPR form in their possession. An appropriate sensitive discussion with the person should aim to secure their understanding and acceptance of the DNACPR decision and in some circumstances a second opinion may be sought to aid these discussions. All of this should be carefully documented.

9.4 People do not have a right to demand that doctors carry out treatment against their clinical judgement. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice must be sought. This should very rarely be necessary.

10. Cancellation of DNACPR decision

10.1 In rare circumstances, a DNACPR decision may be cancelled or revoked. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point ink and the word ‘CANCELLED’ written clearly between them, dated, signed and name/designation printed by the Doctor. The cancelled form is to be retained in the person’s notes. It is the responsibility of the Doctor cancelling the DNACPR decision to communicate this to all parties informed of the original decision.

10.2 Electronic versions of the DNACPR decision must be clearly cancelled and the entry attributable to the responsible clinician.

10.3 On cancellation or death of the person at home, if the ‘ambulance service warning flag’ has been ticked, the health and social care staff dealing with the person, MUST inform the ambulance service that cancellation or death has occurred.

11. Suspension of DNACPR decision

11.1 Uncommonly, some persons for whom a DNACPR decision has been established may develop Cardiac Arrest from a readily reversible cause. In such situations CPR may be appropriate, while the reversible cause is treated, unless the person has specifically refused intervention in these circumstances.

11.2 Acute: Where the person suffers an acute, unforeseen, but immediately life-threatening situation, such as anaphylaxis or choking. CPR may be appropriate while the reversible cause is treated.

11.3 Pre-planned: Some procedures could precipitate a Cardiac Arrest, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the person if appropriate, will need to take place. DNACPR orders for patients in the perioperative period may have 3 options.

- Option 1: the DNACPR decision is to be discontinued. Surgery and anaesthesia are to proceed with CPR to be used if cardiac arrest occurs.
- Option 2: the DNACPR is to be modified to permit the use of drugs and techniques commensurate with the provision of anaesthesia.
- Option 3: no changes are to be made to the DNACPR decision. Under most circumstances this option is not compatible with the provision of general anaesthesia for any type of surgical intervention.

12. Audit

12.1 Organisations will measure, monitor and evaluate compliance with this policy through audit and data collection using agreed Key Performance Indicators.

12.2 All organisations will have clear governance arrangements in place which indicate people and Committees who are responsible for this policy and audit. This includes:

- data collection
- ensuring that approved documentation is utilised
- managing risk
- sharing good practice
- monitoring of incident reports and complaints regarding the DNACPR process
- developing and ensuring that action plans are completed.

12.3 Frequency:

- compliance with the policy will be audited annually using the DNACPR Audit Tool
- local leads will decide the number of DNACPR forms to be examined
- all institutions must store the audit copy of the DNACPR form so that it is easily accessible when the local lead requests the information

12.4 Information will be used for future planning, identification of training needs and for policy review.

13. Measuring performance and audit completion

13.1 For Health and Social Services Acute care setting compliance with the Unified Do Not Attempt Cardiopulmonary Resuscitation 16 years and over Policy will be audited by the Resuscitation Officer on an annual basis and reported to the Resuscitation Committee.

13.2 For Organisations working in the Community care setting compliance with the Unified Do Not Attempt Cardiopulmonary Resuscitation 16 years and over Policy will rely on a spot audit which will take place annually within the community. This audit will be led by the Medical Director, Primary Care working in collaboration with partnership organisations and will rely on access to a copy of the DNACPR form and to GP electronic records. Audit outcomes will be reported to the Integrated Governance Committee (IGC).

14. Development and consultation process

An outline of who has been involved in developing the policy / guidance procedure including HSSD committees, service users and agencies.

14.1 Consultation Schedule

Name of Individual	Title of Individual	Date Consulted
Peter Gavey	Ambulance Chief	October 2017
Rose Naylor	Chief Nurse	October 2017
Irene Campbell	Resuscitation Services Manager	October 2017
Sarah Whiteman	Director Primary Care	October 2017
Nicola Bailhache	Associate Specialist Palliative Care	October 2019
Nigel Minihane	General Practitioner	October 2017
Simon Chapman	Consultant Emergency Medicine	October 2017
Gail Caddell	Director of Palliative Care	October 2017
Julia Foglia	Governance Lead FNHC	October 2017
Tia Hall	Operation Lead FNHC	October 2017
Sian Baudains	General Practitioner	October 2017
Elspeth Snowie	Clinical Effectiveness Facilitator FNHC	October 2017
Julia Foley	Community Sister FNHC	October 2017
Jane Le Ruez Lane	Lay representative	October 2017
Joseph Matia	Legal advisor	January 2018
Timothy Harrison	Consultant Palliative medicine	October 2019
Adrian Noon	AMD PCB, Consultant Emergency Medicine	October 2019

15. Implementation Plan

A summary of how the policy will be implemented

Action	Responsible Officer	Timeframe
This policy will be approved by the	HSSD Policy Ratification Group FNHC Policy Ratification Group Hospice Policy Ratification Group Care Federation Policy Ratification Group	1/12; Q4 2017
This policy will be implemented and disseminated by	Each of the organisations who are signatories	Q4 2017
Awareness of this policy will be created through a variety of methods of communication and a robust standardised training plan will be in place for implementation of this policy.	Dr Sarah Whiteman	Q1 2018
This policy will be published on the	My States website	Q1 2018
Responsibility for making reference to the unified DNACPR process during all relevant HSSD resuscitation training courses	Resuscitation Service (HSSD)	2018
Patient and public awareness raising in communication with Comms Team	All	Q1 2018
To link to other relevant legislation and strategies including eGov, operationalisation of the policy under leadership of Accountable Person within each organisation		
Link to H+C Strategy aka “Co-ordinate My Care’ + use of e-forms within JCR		

16. Glossary of terms / keywords and phrases

Advance care planning: The process of discussing the type of treatment and care that a patient would or would not wish to receive in the event that they lose capacity to decide or are unable to express a preference, for example their preferred place of care and who they would want to be involved in making decisions on their behalf. It seeks to create

a record of a patient's wishes and values, preferences and decisions, to ensure that care is planned and delivered in a way that meets their needs and involves and meets the needs of those close to the patient.

Advance decision to refuse treatment (ADRT): A statement of a patient's wish to refuse a particular type of medical treatment or care if they become unable to make or communicate decisions for themselves. If an ADRT is valid and applicable to the person's current circumstances, it must be respected as it is legally binding. Part 3 of the Capacity and Self-Determination (Jersey) Law 2016 deals with ADRT and there is more information in the associated Code of Practice

Advance statement: A statement of a patient's views about how they would or would not wish to be treated if they become unable to make or communicate decisions for themselves. This can be a general statement about, for example, wishes regarding place of residence, religious and cultural beliefs, and other personal values and preferences, as well as about medical treatment and care.

Artificial nutrition and hydration (ANH): See clinically assisted nutrition and hydration.

Capacity: The ability to make a decision. An adult is deemed to have capacity unless, having been given all appropriate help and support, it is clear that they cannot understand, retain, use or weigh up the information needed to make a particular decision or to communicate their wishes.

Clinically assisted nutrition and hydration (CANH): Clinically assisted nutrition includes nasogastric feeding and percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG) feeding tubes through the abdominal wall. PEG, RIG and nasogastric tube feeding also provide fluids necessary to keep patients hydrated. Clinically assisted hydration includes intravenous or subcutaneous infusion of fluids (use of a 'drip'), and nasogastric tube feeding or administration of fluid. The term 'clinically assisted nutrition and hydration' does not refer to help given to patients to eat or drink, for example spoon feeding.

Clinician: A health professional, such as a doctor or nurse, involved in clinical practice.

DNACPR: Abbreviation of 'Do Not Attempt Cardiopulmonary Resuscitation'. These advance management plans may be called DNAR orders or Allow Natural Death decisions in some healthcare settings.

End of life: Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes those patients whose death is expected within hours or days; those who have advanced, progressive incurable conditions; those with general frailty and co-existing conditions that mean they are expected to die within 12 months; those at risk of dying from a sudden acute crisis in an existing condition; and those with life-threatening acute conditions caused by sudden catastrophic events. The term 'approaching the end of life' can also apply to extremely premature neonates whose prospects for survival are known to be very poor, and patients who are diagnosed as being in a persistent vegetative state (PVS) for whom a decision to withdraw treatment and care may lead to their death.

End stage: The final period or phase in the course of a progressive disease leading to a patient's death.

Legal proxy: A person with legal authority to make certain decisions on behalf of another adult.

Palliative care: The holistic care of patients with advanced, progressive, incurable illness, focused on the management of a patient's pain and other distressing symptoms and the provision of psychological, social and spiritual support to patients and their family. Palliative care is not dependent on diagnosis or prognosis, and can be provided at any stage of a patient's illness, not only in the last few days of life. The objective is to support patients to live as well as possible until they die and to die with dignity.

Second opinion: An independent opinion from a senior clinician (who might be from another discipline) who has experience of the patient's condition but who is not directly involved in the patient's care. A second opinion should be based on an examination of the patient by the clinician.

Those close to the patient: Anyone nominated by the patient, close relatives (including parents if the patient is a child), partners, close friends, paid or unpaid carers outside the healthcare team, and independent advocates.

Appendix 1

Medical Notes copy

Complete or affix label here. If a label is used affix a label on each part of the triplicate form.

Surname:

Forename:

Date of birth:

HSS number:

Jersey Hospice Care
your care, your choice, your law

Government of JERSEY

PRIMARY CARE BODY

Family Nursing & Home Care

MEDICAL NOTES COPY
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ON THIS PATIENT
(FOR ADULTS AGED 16 AND OVER)

Date and Time of commencement of DNACPR / / : AM PM

The patient has capacity to make and communicate decisions about CPR:	Yes	No
The patient has completed a valid advance decision (ADRT):	Yes	No
The decision has been discussed with the patient:	Yes	No
The decision has been discussed with those identified as important to the patient	Yes	No

Reason for DNACPR order (*Tick if appropriate*):

The patient has refused CPR:	
The patient agrees that CPR should not be attempted;	
CPR is very unlikely to restart the patients heart and breathing;	
The likely outcome of successful CPR would not be of overall benefit to the patient	

(The patient's informed views and wishes are of paramount importance to the decision)

Summary of main clinical problems and reasons why CPR would be not be appropriate:

Summary of communication with patient, relatives, friends or legal representation:

Note: Please document in medical notes evidence that the above has been discussed with either the patient or relative (S)

Name, Grade and signature of Doctor completing this form:

If the doctor is not a consultant or GP, the decision should be countersigned by a consultant at or a GP at first review. If the doctor is a post fellowship specialist registrar, staff grade or associate specialist,(excluding Palliative care) the doctor must speak with the consultant or GP and gain verbal consent the DNACPR order.

I have discussed this decision with: Insert name of Consultant/GP here

Countersignature of Consultant/GP:
(To be signed at first patient review)

Is DNACPR decision indefinite?: Yes ☐ No ☐ If 'no' please specify review date: / /

If DNACPR order is to be cancelled score through the original form and sign. Remove DNACPR TrakCare alert and tell GP

Patient copy

Complete or affix label here. If a label is used affix a label on each part of the triplicate form.

Surname:

Forename:

Date of birth:

HSS number:

Jersey Hospice Care
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PRIMARY CARE BODY

Family Nursing & Home Care

PATIENT COPY
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ON THIS PATIENT
(FOR ADULTS AGED 16 AND OVER)

Date and Time of commencement of DNACPR / / : AM PM

The patient has capacity to make and communicate decisions about CPR:	Yes	No
The patient has completed a valid advance decision (ADRT):	Yes	No
The decision has been discussed with the patient:	Yes	No
The decision has been discussed with those identified as important to the patient	Yes	No

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I have discussed this decision with: Insert name of Consultant/GP here

Countersignature of Consultant/GP:
(To be signed at first patient review)

Is DNACPR decision indefinite?: Yes ☐ No ☐ If 'no' please specify review date: / /

If DNACPR order is to be cancelled score through the original form and sign. Remove DNACPR TrakCare alert and tell GP

Audit copy

Complete or affix label here. If a label is used affix a label on each part of the triplicate form.

Surname:

Forename:

Date of birth:

HSS number:

Jersey Hospice Care
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Government of JERSEY

PRIMARY CARE BODY

Family Nursing & Home Care

AUDIT SHEET
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ON THIS PATIENT
(FOR ADULTS AGED 16 AND OVER)

Date and Time of commencement of DNACPR / / : AM PM

The patient has capacity to make and communicate decisions about CPR:	Yes	No
The patient has completed a valid advance decision (ADRT):	Yes	No
The decision has been discussed with the patient:	Yes	No
The decision has been discussed with those identified as important to the patient	Yes	No

Reason for DNACPR order (*Tick if appropriate*):

The patient has refused CPR:	
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Countersignature of Consultant/GP:
(To be signed at first patient review)

Is DNACPR decision indefinite?: Yes ☐ No ☐ If 'no' please specify review date: / /

If DNACPR order is to be cancelled score through the original form and sign. Remove DNACPR TrakCare alert and tell GP

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