Health and Community Services

Jersey Multi-agency Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

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DOCUMENT PROFILE

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Government of Jersey

1 INTRODUCTION

1.1 Rationale

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

This policy applies to all 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 18 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

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.
   - A valid and applicable Advance Decision, known in law as an Advance Decision to Refuse Treatment (ADRT), prohibits CPR.
   - Other specified reasons apply.

2. Clear evidence of a recent verbal refusal of CPR, while the individual had capacity, should be carefully considered when making a best interest decision. Good practice requires documenting the verbal refusal and any decisions contrary to it must be robust, accounted for, and documented. The individual should be encouraged to make an ADRT to ensure adherence to their verbal refusal.

3. CPR should not be attempted for individuals clinically assessed to be at the end of life, where it is unlikely to restart the heart and breathing. Inform the individual and/or their relatives/carers of this decision where possible unless the patient does not want the CPR decision shared.

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

5. Individuals with long-term conditions and a chance of CPR success should be asked if they wish for it to be performed. They may involve family or friends in this decision.

6. If the individual lacks capacity to discuss and decide, those close to the patient should be asked about the person's known wishes regarding resuscitation. The Capacity and Self-Determination (Jersey) Law 2016 and associated code of practice provide information on assessing capacity and making best interest determinations for those who lack capacity. All discussions and decisions should be clearly documented. Persons, family, or friends have the right to refuse participation in discussions.

7. A standardised Island-wide form for DNACPR decisions will be used for individuals aged 18 years and over.

8. Effective communication about the individual's resuscitation status should occur among all members of the multidisciplinary healthcare team and across all 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 to ensure it provides a robust framework underpinned by relevant national guidance and legislation. This policy does not constitute legal advice. Specific legal advice should be sought when necessary. Organisations may also wish to have the policy 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. DNACPR decisions refer only to CPR and not to any other aspect of the person's care or treatment options.

3 CORPORATE PROCEDURE

3.1 Legislation and guidance

3.1.1 Legislation / Policy

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.

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).

3.1.2 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 (2020) Resuscitation Council (UK), available at
Quality Standards: Acute Care | Resuscitation Council UK

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

3.2 Roles and Responsibilities

This policy and its forms and appendices apply to all health and social care staff working within signatory organisations including

- primary
- secondary
- independent
- ambulance
- voluntary

It applies to all designations and roles. It applies to all people employed and learners in a caring capacity, including those employed privately by any agency who are signatories to the policy.

The decision to complete a DNACPR form should be authorised by a Consultant, General Practitioner or other Doctor who has been delegated the responsibility by their employer.

In addition, an SAS grade doctor can decide 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 (General Practitioners) are not available then a designated deputy may decide. These are a specialist possessing the relevant Royal College Fellowship or Membership, a staff grade Doctor or Associate Specialist nominated by the Consultant.

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, to follow a unified approach to storage of information in the home setting.

3.2.1 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.

3.2.2 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.

3.2.3 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 deciding 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.

3.2.4 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.

3.2.5 Ambulance staff

Must ensure they adhere to the policy including relevant organisational policies, procedures, and guidance.

3.2.6 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.

3.3 Process

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.

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 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 interest's 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.

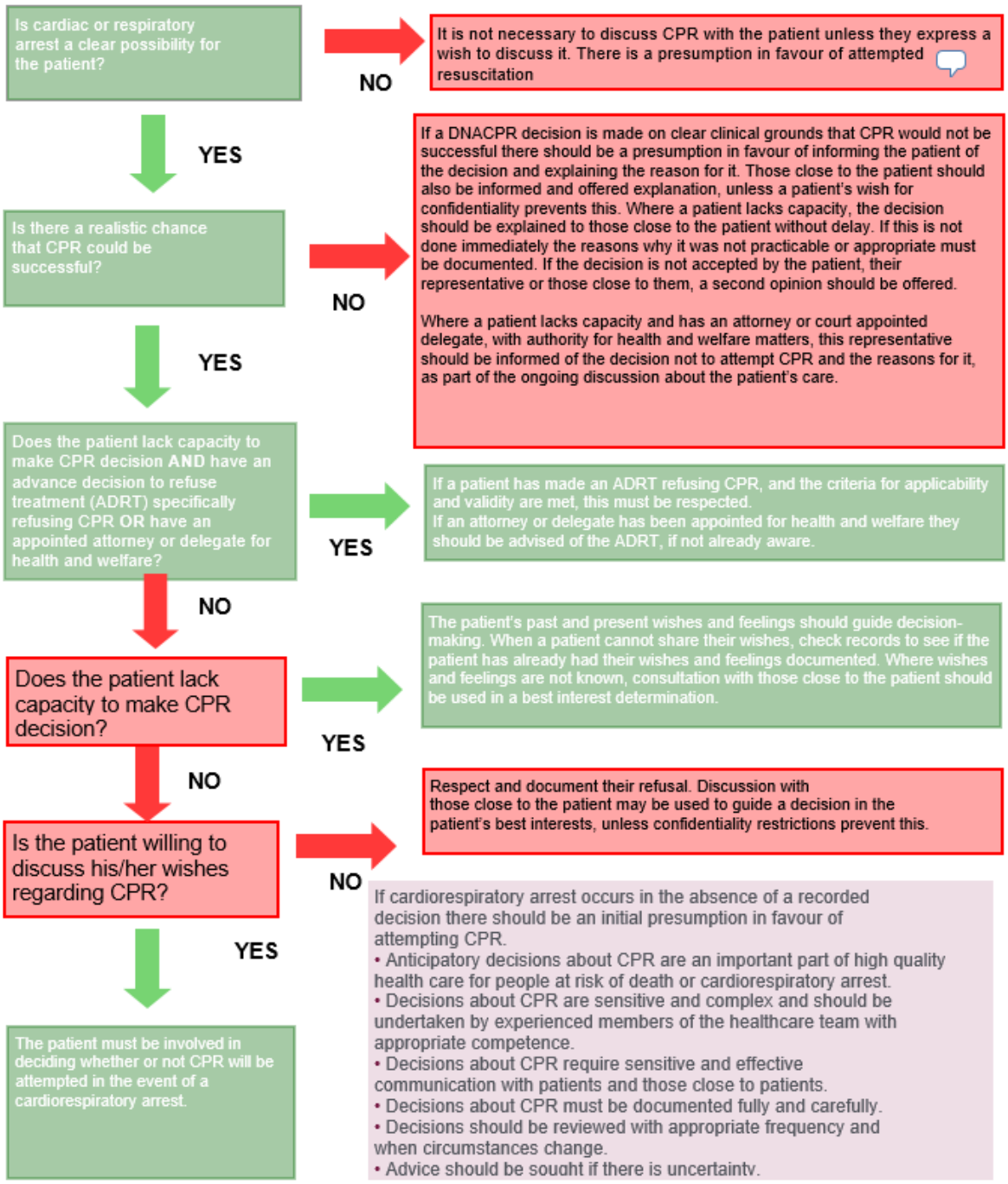
The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

- 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 accordance 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).

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 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.
- Clinicians should establish whether someone holds a Power of Attorney or is a Delegate if the patient lacks capacity. Clinicians should identify relatives and discuss the proposed DNACPR approach with them in any event.

Decision - making framework



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

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 and on a unified DNACPR specific form.
- 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 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, e.g. likely to result in irreversible harm.
- 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 those close to the patient 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.

3.4 Documenting and communicating the decision

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

- Document the decision in the medical notes, 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.

A copy of the form should always stay with the person (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. When using EPR an electronic alert will be visible.

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.
- Should be included in any clinical handover and discharge summary.
- 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.

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.

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. For agencies that use MAXIMS or EMIS an indefinite DNACPR form must be uploaded to MAXIMS (appendix 2).

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.

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.

3.5 Discharge amd transfer process

In addition, when the decision was made and 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.

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.

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.

3.5.1 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 and relatives as appropriate.

3.5.2 Non-ambulance transfer

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

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.

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.

3.6 DNACPR

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.

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.

3.7 Situation where there is lack of agreement regarding DNACPR decisions

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 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 it 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.

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 and documented.

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.

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.

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. Your patient, those close to them and anyone appointed to act for them should be informed as early as possible of any decision to start legal proceedings, so they have the opportunity to participate or be represented.

3.8 Cancellation of DNACPR decision

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 as directed in the authorising guidance. 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.

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

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.

3.9 Suspension of DNACPR decision

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. To avoid misunderstandings it may be helpful, whenever possible, to make clear to patients and those close to patients that DNACPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest and not to an unforeseen event such as a blocked airway.

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

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.

This includes the timeframe of the suspension postoperatively. 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.

1. Option 1: the DNACPR decision is to be discontinued. Surgery and anaesthesia are to proceed with CPR to be used if cardiac arrest occurs.
2. Option 2: the DNACPR is to be modified to permit the use of drugs and techniques commensurate with the provision of anaesthesia.
3. 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.

3.10 Audit

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

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.

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.

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

3.11 Measuring performance and audit completion

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

For Organisations working in the Community care setting compliance with the Unified Do Not Attempt Cardiopulmonary Resuscitation 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).

4 CONSULTATION AND DEVELOPMENT PROCESS

A record of who is involved in the development of this document. This may include HCS committees, service users and other agencies.

4.1 Consultation Schedule

Name and Title of Individual	Date Consulted	Response received (Y / N)
Irene Campbell HCS Resuscitation Service Manager	07/03/24	Y
Caroline Jenkins Consultant Anaesthetist, Resuscitation Committee Chair	07/03/24	Y
James Inglis Senior ambulance office Governance and Risk	07/03/24	Y
Nicola Bailhache Associate specialist palliative care	07/03/24	Y
Adrian Noon Chief of medicine	07/03/24	Y
Andrea Firby Primary Care Governance	07/03/24	Y
James Grose Consultant Palliative Care	07/03/24	Y
Toby Farlan Capacity and self-determination Law Lead	03/06/24	Y
Ricardo Da Silva Digital Nurse	07/03/24	Y
Hannah Lowe Nurse FNHC	07/03/24	Y
Matt Doyle Associate medical officer	07/03/24	Y
Alex Watt Lead nurse Womens and Children's	07/03/24	N
Hazel McWhinnie Head of nursing and AHP Education	07/03/24	Y
Maria Finn Consultant Emergency Medicine	07/03/24	N
Muktanshu Patil Consultant Paediatrics	07/03/24	N
Olivia Card Lead nurse Mental Health	07/03/24	Y
Pamela Le Sueur Associate Director Quality and Safety	07/03/24	N
Valerie Mee Senior Resuscitation Officer	07/03/24	Y
Libby Paisley Practice development Learning Disabilities	07/03/24	Y
Conor Quinn Resuscitation officer	07/03/24	Y
Robert Gardner Head of learning disabilities	07/03/24	N
Anne Hughes Nurse FNHC	30/05/24	N
Claire Baker Nurse FNHC	30/05/24	N
Angela Stewart Nurse FNHC	30/05/24	N
Joanna Champion Nurse FNHC	30/05/24	N
Michelle Margetts Nurse FNHC	30/05/24	N
Kirby Lyons Nurse FNHC	30/05/24	N
Ann Morgan Nurse FNHC	30/05/24	N
Tia Hall Operational Lead for Adult services	03/06/24	Y
Nadya Wolferstan Legal advisor LOD	28/06/24	Y

Name of Committee / Group	Date of Committee / Group meeting
Resuscitation Committee	June 2024
PPRG	July 2024

4.2 Development

Applicable NICE guidance	Details of deviations
N/A	

If the operational practice outlined in this procedural document deviates from NICE or Royal College guidelines you must complete this form:
https://forms.office.com/e/T1uTxjyM4c

5 REFERENCE DOCUMENTS

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6 GLOSSARY OF TERMS, KEYWORDS AND PHRASES

Definitions of technical or specialised terminology used within your document.

Term	Definition
Advance care planning	The process of discussing the type of treatment and care that a patient would or would not wish to receive if 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 extremely 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.

Learners	Student nurses, medical students, AHP students.
Health and Social care	All multi agency healthcare providers

7 IMPLEMENTATION PLAN

A summary of how the document will be communicated and put into practice.

Action	Responsible Officer	Timeframe
Ratification with the Policy and Procedure Ratification Group (PPRG)	Nicola Kill	12 July 2024
Upload to HCS Intranet	Nicola Kill	July 2024
HCS comms email	Irene Campbell	July 2024
Present to care group governance meetings	Irene Campbell	July 2024
Share policy with Primary care body governance, FNHC governance and Hospice Governance for ratification with those bodies	Irene Campbell	July 2024
Primary care, FNHC and Hospice Governance leads to ratify and implemnent the policy	Primary Care Dr Matt Doyle & Andrea Firby FNHC Elspeth Snowie Hospice Dr James Grose & Dr Nicola Balliache	July 2024

8 AUDIT

A summary of how the implementation and compliance will be monitored.

Minimum requirement to be monitored WHAT elements of compliance will be monitored	**Responsible individual** WHO is going to monitor this element	**Process for Monitoring** How will this element be monitored	**Frequency for monitoring** WHEN will this element be monitored / how often	**Responsible individual or committee** WHERE - which individual / committee will this be reported to
Documentation of the DNACPR complete	HCS Resuscitation Service Other agencies responsible for their own audit and compliance	DNACPR forms daily reviews Point prevelance Annual audit Care rounding	Daily Weekly Annually	Resuscitation Committee Other agencies responsible for their own audit and compliance
Communicating Decisions to patient and families	HCS Resuscitation Service	DNACPR forms daily reviews	Daily Weekly Annually	Resuscitation Committee Other agencies responsible for

	Other agencies responsible for their own audit and compliance	Point prevelance Annual audit Care rounding		their own audit and compliance
Clinican rationale for DNACPR	HCS Resuscitation Service Other agencies responsible for their own audit and compliance	DNACPR forms daily reviews Point prevelance Annual audit Care rounding	Daily Weekly Annually	Resuscitation Committee Other agencies responsible for their own audit and compliance

8.1 Audit

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

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.

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.

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

8.2 Measuring performance and audit completion

For Health and Social Services Acute care setting compliance with the Unified Do Not Attempt Cardiopulmonary Resuscitation 18 years and over Policy will be audited by the Resuscitation Officer on an annual basis and reported to the Resuscitation Committee.

For Organisations working in the Community care setting compliance with the Unified Do Not Attempt Cardiopulmonary Resuscitation 18 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).

9 APPENDICES

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:

URN:

Jersey Hospice Care
your care, your choice, your time

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 Maxims/EMIS alert and inform relevant Health care providers

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:

URN:

Jersey Hospice Care
your care, your choice, your time

Government of JERSEY

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
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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 Maxims/EMIS alert and inform relevant Health care providers

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:

URN:

Jersey Hospice Care
your care, your choice, your time

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

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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 Maxims/EMIS alert and inform relevant Health care providers

Appendix 2 MAXIMS DNACPR