SUPPORTING DNACPR INFORMATION
FOR CARE HOMES

KEY POINTS relating to DNACPR DECISIONS

DNAR considerations:

Where no explicit decision has been made in advance, there should be an initial presumption in favour of CPR.

The primary responsibility in the Care Home concerning the making and recording of DNACPR decisions lies with the GP who has medical responsibility of the resident at the time. However, Care Home staff will be closely involved as they are often the ones with the most up to date knowledge of the resident.

Decisions about CPR must be made on the basis of an individual assessment of each resident's case.

A DNACPR decision should be considered for all residents who are on GP Palliative/End of Life registers as they fulfil the criteria that the team 'wouldn't be surprised' if the resident deteriorated and died in the next 12 mths.

If the individual has an irreversible condition where death is the likely outcome, (i.e., due to the advanced nature of their disease/frailty) he/she should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual. Ensure the decision is documented.

If CPR would not re-start the heart and breathing (i.e. patient clearly died a length of time before being discovered), CPR should not be attempted. (This decision cannot be made by an unqualified member of staff).

DNACPR decisions apply only to CPR and not to any other aspects of treatment, nor does it override clinical judgement if there is an immediately reversible cause of the resident's respiratory or cardiac arrest (i.e. as a result of choking or anaphylaxis). This is unless the resident has a valid and applicable ADRT to state otherwise.

Communication Considerations:

It is not necessary to initiate DNACPR discussions/decisions unless the resident is felt to be at risk of a cardio-respiratory arrest (or should choose to discuss).

For those who it is felt are likely at risk of cardio-respiratory arrest and for whom resuscitation may be successful, where it is felt the expected benefits of CPR may be outweighed by the burdens, the resident's informed views are paramount. Where the resident lacks capacity, those close to them should be involved in discussions to explore the resident's wishes, feelings and values that can help inform the medical decision. If there is no one (other than paid carers)to involve then an **Independent Mental Capacity Advocate** (IMCA) should be consulted.

Mental Capacity Considerations:

If a resident with capacity refuses CPR in advance, or a resident lacking capacity has a valid and applicable Advance Decision to Refuse Treatment (ADRT) refusing CPR, this should be respected.
If a resident without capacity has appointed a Lasting Power of Attorney (LPA) for Health and Welfare they may legally make the decision in favour of DNACPR, but cannot insist on CPR. (Ensure the section relating to giving the attorney authority to give or refuse consent for life-sustaining treatment has been completed).

Documentation you may see a DNACPR decision in:

Patient held unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decision form (lilac)
It is a legal requirement that this is recorded in the patient's medical notes at the GP Practice.
If a Care Plan for End of Life is in place then a uDNACPR form is still required
A DNACPR order form completed in the community is acceptable within the hospital setting providing they see the original lilac copy.