Acacium Group

Do Not Attempt Resuscitation Policy

Policy Reference | CLIN 40

Version | V5.1

Policy Name	Do Not Attempt Resuscitation Policy
Purpose of Document	To provide guidance to all Acacium Group staff regarding DNAR/DNACPR order/ACP/ReSPECT status and management.
Target Audience	Acacium Group Staff
Version	V5.1
Author	Kate Nicholson-Florence
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Lead Director	Karen Matthews-Shard
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Next Review Date	April 2025
Risk and Resource Implications	**Resource:** Training. Care Plans & Appropriate Documentation. **Risk:** Resuscitation of Client/Patient/Service User being initiated when a DNAR/ACP/ReSPECT is in place Workers in the community - Temporary workers moving from one area to another, who may not have an understanding/be aware of the service users wishes or may not have seen/have access to the appropriate documentation.
Associated Strategies and SOPs	See page 14-15
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
Draft 1	May 2015	First draft	KNF
V1	Jun 2015	Published	KNF/KMS
V1	Jun 2016	Annual Review	KNF/SJ
V1.1	Oct 016	Updated legislation	KNF/SJ
V1.1	Jan 2017	Implementation of new policy template	KNF/SJ
V1.1	Jun 2017	Annual review	KNF/VM
V1.1	Nov 2017	Updated to include new TCS bio brand description page.	LB / MS
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V1.2	Mar 2020	Updated to new Template	CC
V2	May 2020	Yearly Review	Clinical Advisory Group
V2.1	Oct 2020	Update re Rebrand	CCR/CC
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V4	May 2023	Annual Review	Clinical Advisory Group
V5	Jan 2024	Rebrand	Clinical Advisory Group
V5.1	Apr 2024	Reviewed and rebranded	Clinical Advisory Group

Table of Contents

1. Introduction

1.1 Acacium Group is aware that decisions about attempting cardiopulmonary resuscitation (CPR) raises very sensitive issues for service users/patients and their relatives, significant others and friends.

1.2 This policy identifies legal and ethical standards for decision making in relation to Do Not Attempt Resuscitation (DNAR/DNACPR/ACP) orders along with other legal documentation that details the service user's/patient's wishes such as ReSPECT and ceiling of care Documentation.

1.3 This policy is based on the guidelines produced by the British Medical Association, Royal College of Nursing and Resuscitation Council UK.

1.4 Decisions about DNAR/CPR order/ACP may apply and be made in various settings including people's homes, hospitals, hospices, nursing homes and transfers between settings.

1.5 The Resuscitation Council UK states that:

- Conversations regarding what to do in a future health and care emergency are essential, when understanding what is important to the person. Discussing and documenting personalised recommendations for an individual's clinical care and treatment is crucial, as in the future they may be unable to express what is important to them. Access to robust and recognisable communication in a health crisis is key to ensuring conversations can transform the care experience when it matters most. That is why Resuscitation Council UK (RCUK) is leading on the UK-wide adoption of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process. The ReSPECT process is unique as it is the only Emergency Care and Treatment Plan (ECTP) that spans all ages and is available throughout the United Kingdom. It is increasingly being adopted within health and social care communities around the United Kingdom, including over 80% of counties in England, some areas of Scotland and in Northern Ireland. Resuscitation Council UK advocates making ReSPECT a nation-wide process which promotes parity across the four nations. ReSPECT supports professionals, patients and/or their families having a personcentred conversation around making recommendations about their care and treatment in a future emergency in which they are unable to communicate this for themselves. Discussing realistic future care and treatment options for that individual enables care goals and values to be shared and agreed. A summary of this conversation is recorded on a ReSPECT plan, creating a unified and nationally recognised process to ensure that conversations about CPR are included as part of a broader conversation about realistic goals of care and treatment. The plan crosses all geographical boundaries and is recognised in every health and care setting. It is a clinical document intended to help clinicians make individualised clinical decisions in an emergency. The ReSPECT plan belongs to the person and should be readily available in an emergency.

1.6 DNACPR decisions only apply to attempting CPR, all other treatment should continue and details of this should be included within all documentation and may include:

- Oxygen therapy
- Suctioning airways
- Administration of Intravenous Antibiotics (IVAB)
- Non-invasive ventilation.

  Please note this list is not exhaustive as DNACPR should be individualised and person centred

1.7 Treatment intervention decisions may apply to other aspects of intervention some examples are listed below, please note this list is also not exhaustive

- Respiratory for example reversal of hypoxia
- Fluid resuscitation

- Antibiotic intervention
- Nutrition and hydration
- Administration of medication
- Admission to hospital

2. Scope of Policy

2.1 This policy applies to all healthcare workers working for Acacium Group, in addition to following the polices of the clients.

2.2 The purpose of the policy is to set out guidance to avoid inappropriate resuscitation, (where applicable ensure that appropriate resuscitation and relevant measures are commenced). Always ensure the needs and wishes of the service user/patient are met and are clearly and legally documented. To ensure all DNAR/DNACPR order/ACP decisions/ReSPECT are transparent and suitable for the individual circumstances of the service user/patient.

2.3 The aims of the DNAR/DNACPR order/ACP policy are:

- To ensure service users/patients receive appropriate and effective resuscitation when appropriate, necessary and without delay.
- To ensure service users/patients are treated with dignity and their wishes and rights are respected.
- To promote current and up-to-date practice, based on the British Medical Association (BMA), Royal College of Nurses (RCN), the Resuscitation Council (UK), Nursing and Midwifery Council (NMC), Healthcare Professionals' Council (HCPC); Medical Register and the General Medical Council (GMC) guidelines and the Mental Capacity Act Code of Practice.
- To implement a consistent and transparent approach to DNAR/DNACPR order/ACP decision making and support service users/patients, and their relatives, significant others and friends in these discussions and decisions.
- To provide support for all Acacium Group workers
- To comply with legal requirements, documentation and minimise clinical risk, litigation and material loss
- To comply with Department of Health requirements.
- To comply with ReSPECT and Ceiling of Care

3. Definitions

Definition	Explanation
DNAR	Do Not Attempt to Resuscitate orders apply only to cardiopulmonary resuscitation, it does not imply "non-treatment".
Cardiopulmonary Resusitation (CPR)	Cardiopulmonary Resuscitation is undertaken in an attempt to restore breathing and spontaneous circulation in a service user in cardiac and/or respiratory arrest.
DNACPR	This is the process in which the decision not to undertake CPR is made.
Health and Welfare Lasting Power of Attorney (LPA)	A person with capacity can appoint a person they trust as an "attorney" to make decisions for them if they lose mental capacity. The court can also appoint an "attorney" for people who do not have capacity to appoint their own. A health and welfare LPA give the attorney the power to make decisions about daily routine, medical care, and life-sustaining medical treatment. It can only be used if the

	individual is unable to make your own decisions and the "attorney will be registered with the Office of the Public Guardian.
Advanced Statement	An advance statement is a written statement that sets down your preferences, wishes, beliefs and values regarding your future care. It can cover any aspect of your future health or social care. The aim is to provide a guide to anyone who might have to make decisions in your best interest if you have lost the ability to make or communicate decisions. An individual can write an advance statement themselves, as long as they have the mental capacity to make the statements. An advance statement is not legally binding, but anyone who's making decisions about the individual's care must take it into account.
Advanced Decision	An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision an individual can make now to refuse a specific type of treatment at some time in the future. It lets family, carers and health professionals know their wishes about refusing treatment if the individual is unable to make or communicate those decisions themselves. An advance decision is not the same as an advance statement (see above definition) and it is legally binding if completed correctly.
ACP	Advance Care Planning' (ACP) is the term used to describe the agreed care, future wishes, needs, preferences and priorities of care, for people nearing the end of their life. It enables better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. Advanced Care Planning ensures that service users **receive medical care that is consistent with their values, goals and preferences.**
ReSPECT (Appendix G)	A ReSPECT form is a very specific type of Advanced or Anticipatory care planning (ACP) that summarises the emergency care aspect of a wider ACP process. ReSPECT records that information so as to make it accessible rapidly to professionals who need to make immediate decisions about care and treatment in a crisis.
Ceiling of Care	The concept of Ceiling of Care derives from the ACP. The aim is to provide guidance to admitting staff who do not know the service user, so that there is continuity with the service users' previously expressed wishes, and/or limitations to their treatment are clear.
Treatment Escalation Plan (TEP)	A Treatment Escalation Plan (TEP) is a tool which records and communicates the personalised and realistic goals of treatment. It should reflect the values and preferences that are important to the person receiving care if their condition should deteriorate.

4. Roles & Responsibilities

4.1 The general overall organisational roles and responsibilities are set out in the policy for Drafting, Approval and Review of Policies and SOPs.

4.2 The following table outlines the responsibilities of the key people involved in this policy.

Job Title	Responsibilities
The Acacium Group Board	Has overall responsibility for ensuring that Acacium Group has robust clinical governance arrangements in place.
Chief Executive	Has overall accountability for all governance, both clinical and corporate arrangements within Acacium Group.
The Operations Board	Is responsible for ensuring that business planning processes are constructed in such a way as to require that clinical governance is considered as part of normal business activities and for ensuring that effective clinical governance arrangements are in place throughout the group.
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.
Line managers/ appropriate others	Are responsible for: • Ensuring that any relevant equipment is provided, ensuring the workers access training, supervision and support relevant to their roles and current responsibilities. • Supporting their workers before, during and after resuscitation incidents / decisions not to resuscitate and monitor compliance with this policy.
Individual workers	Responsibilities include: • Be aware of and comply with Acacium Group policy for DNAR • Record any decision not to resuscitate in the service users care plan and ensure this is highlighted to all those caring for the service user • Take part in training, including attending updates so that they maintain their skills and are familiar with resuscitation processes • Keep a personal record of any training attended
Clinical Advisory Group (CAG)	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

5. DNAR/DNACPR Order/ACP/ReSPECT

5.1 A DNAR/DNACPR order/ACP/RESPECT can only be made by a medical professional. Service users who are adults with capacity or a child with gillick competence can make an advanced decision regarding their resuscitation status.

5.2 The decision to implement a DNAR/DNACPR order/ACP/ReSPECT can happen in advance, as long as the decision is made at a time when the service user has capacity. It remains valid when the service

user ceases to have the necessary capacity. Healthcare professionals are legally bound to respect their decision.

5.3 The decisions regarding the service user competence to make the decision and the nature of the treatment to be given or withheld is the responsibility of the leading physician (usually the GP in the community setting and the Consultant in the acute setting).

5.4 Validity of a DNAR document:

- Signed and dated
- No significant changes in the service user's condition/treatment
- Reviewed within the specified date/still in date
- Reasons

5.5 Some service users/patients will have restrictions in place to determine the length of CPR attempt or the type of CPR, this are called 'Restricted CPR Attempts', for example:

- Treatment of shockable rhythms
- Treatment of respiratory arrests
- Length of time spent doing CPR

5.6 A decision that CPR will not be attempted can sometimes be made because the risks outweigh the benefits. These decisions should only be made by senior medical professionals after careful consideration of the below factors: (Decisions relating to CPR; BMA, RCN RCUK). Refer to Appendix D.

- The likelihood of re-starting the person's heart and breathing for a sustained period and resuscitation attempts would be deemed futile.
- The level of recovery that can be expected realistically after successful CPR
- The person's known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values of those who lack capacity
- The person's human rights, including the right to life, the right to be free from degrading treatment, which may include a dignified death, and the right to respect for a private and family life
- The likelihood of the person experiencing continuing pain or suffering that they would find intolerable or unacceptable
- It should not be made on age alone

5.7 Healthcare professionals discussing and communicating CPR (DNAR) decision to service users, and those close to them should be:

- offer as much information as desired(with due regard for the service user/patient's wishes concerning confidentiality)
- open and honest
- use clear, unambiguous language,
- use a combination of verbal discussion and printed information
- provide information in formats which people can understand, this may include the need for an interpreter or easy-to-read formats
- check understanding
- where possible, communicate decisions in an appropriate environment and allow adequate time for discussion and reflection.
- the level of awareness the person being made DNAR's capacity and insight..

6. What to do if a service user requires CPR with no DNAR

6.1 **If no explicit decision has been made in advance about CPR and the express wishes of a person are unknown and cannot be ascertained, there should be an initial presumption that healthcare professionals will make all reasonable efforts to resuscitate the person in the event of a cardiac or respiratory arrest. (Decisions relating to CPR – BMA, RCN RCUK)**

6.2 The following steps should be taken if a service user/patient requires CPR and their wishes are not known:

- Medical help should be called immediately and under no circumstances should staff take it upon themselves NOT to call for emergency services/assistance.
- In the absence of clear instructions/documentation to the contrary CPR should be commenced.
- If possible immediate access to the relevant medical records should be sought and/or urgent advice obtained from the service user's GP or consultant

7. What to do if a service user requires CPR with a DNAR/DNACPR Order/ACP

7.1 Carrying out CPR where there is a DNAR in place by the expressed wishes of the service user's/patient is theoretically an assault and is technically actionable in both Criminal and Civil Court and the relevant professional body.

7.2 If there is a DNAR/ReSPECT/Ceiling of Care in place, the following steps should be followed:

- The original DNAR/DNACPR order/ACP order or details of any notes relating to such a request should be made available to the emergency services or healthcare workers who attend to the service user.
- Where there is an in date DNAR order signed by the GP or consultant on file, this has been recently reviewed and, there is no other reason to doubt its validity the healthcare worker should not attempt CPR.

7.3 The scope of the DNAR should be stated within the care plan. The actions required in the event a foreseeable life-threatening event, such as choking in a patient with a known swallow risk and the abdominal thrust may preserve life must also be stipulated in relevant care plans.

8. What to do if a service user requires CPR when there is uncertainty about a DNAR/ReSPECT etc.

8.1 If there is any doubt as to the existence of a valid and up to date DNAR request signed by the service user's GP or Consultant or relevant medical practitioner then the healthcare worker is obliged to perform CPR in accordance with their training and if they deem themselves competent to do so.

8.2 In some emergency situations a DNAR form may not be known about or found and CPR may be attempted. If a DNAR document is found or the emergency services/ GP inform you that a DNAR exists, CPR should be stopped in accordance with the document.

8.3 DNAR/DNACPR order/ACP will detail whether a review is required, where a date for review is listed the DNAR/DNACPR/ACP must be reviewed prior to the expiry date. If the date has expired without review the DNAR/DNACPR/ACP is not valid.

8.4 Where a DNAR/DNACPR/ACP does not have a review date, the document will remain active and must be followed unless there has been any circumstantial changes i.e. Service users condition has improved, change of address at which point the DNAR/DNACPR order/ACP must be reviewed.

9. Advanced Care Planning in Adults

9.1 Advanced Care Planning (also known as "Advanced Decisions" and "Advanced Directives" and "Living Wills") sets out in detail the treatments an individual would or would not wish to receive if they become unconscious, unable to communicate their wishes or otherwise lack the mental capacity to make a decision.

9.2 Advanced care planning can include a DNAR/DNACPR order/ACP request and such specific refusals of treatment are legally binding providing they are properly made.

9.3 The legal status of the above is not normally straightforward. There are previous cases that have established a precedent that an unambiguous advanced care plan refusal of treatment made by a competent adult is legally binding after the loss of capacity or consciousness and failure to respect this had been found to provide grounds for an action for assault.

9.4 There are circumstances when an advanced care plan/decision can be overridden (should only be overridden by a senior person):

- Can be overridden if the person is being treated under the Mental Health Act 1983; or
- May be overridden if there is any question over whether the person had mental capacity to make the decision at the relevant time, or if at the time it was made the individual did not appreciate the implications of refusing treatment; or
- May not be followed where there is any challenge to the validity of the decision
- In all cases, the status of a DNAR or other Advanced Decision/Directive is primarily a matter for the medical professionals involved.

10. Paediatrics and Young People

10.1 As with adults, decisions about CPR must be made on the basis of an individual assessment of each child or young person's current situation.

10.2 A DNAR decision in children/young people ONLY relates to attempting CPR and does not relate to any other ongoing treatment or care the child/young person is receiving. Clinical interventions such as oxygen therapy and suctioning the airway should still be completed when appropriate or as detailed within their individual care plan.

10.3 Any decision must be made on an individual basis "ideally clinical decisions relating to children and young people should be taken with a supportive partnership involving service users, their families and the healthcare team " (UK resuscitation Council, BMA, RCUK and NMC (2016).

10.4 The decision to involve the child/young person in the decision making must be assessed on an individual basis. National guidance suggests that "where CPR may re-start the heart and breathing for a sustained period but there are doubts about whether the potential benefit outweigh the burdens, the views of the child or young person should be taken into consideration in deciding whether it should be attempted" (UK Resuscitation Council, BMA, RCUK and NMC (2016).

10.5 In children there should be a presumption in favour of attempting resuscitation unless a decision has been made otherwise.

10.6 Where a competent young person makes an informed advance refusal of CPR, health care professionals should seek legal advice if they believe that CPR would be beneficial (UK Resuscitation Council, BMA, RCUK and NMC (2016)

10.7 Usually it is possible to reach agreement on whether or not CPR should be attempted if a child or young person suffers a respiratory or cardiac arrest. A Parent/Guardian with parental responsibility/competent young person is able to revoke a DNAR at any time, however parents cannot require doctors to provide treatment contrary to their professional judgement, but doctors should try to accommodate parents' wishes. If there is genuine uncertainly about the child/young person's best interests, legal advice should be sought. (UK Resuscitation Council, BMA, RCUK and NMC (2016)

10.8 Reviewing a decision: It may be stated on the DNAR form when a review should be carried out. Decisions about DNAR should be reviewed when there are any changes in the child/young person condition, treatment and wishes, or prior to any procedures where cardio-respiratory arrest is a risk.

11. Advanced care planning in Children and Young People

11.1 When a child or young person has a life-limiting condition it may be that they will have an advanced care plan in place, this is a formal care plan that will document the child's (in conjunction with their parents/guardians) wishes, it is important to recognise that the parents/guardians play a central role in decision making and care planning (NICE 2016 – Updated 2019)
https://www.nice.org.uk/guidance/ng61/resources/end-of-life-care-for-infants-children-and-young-people-with-lifelimiting-conditions-planning-and-management-pdf-1837568722885

11.2 An advanced care plan (which can also be known as an 'end of life plan' or end of life wishes document) captures discussions between the child/family and professionals about the child's care and brings together wishes and needs of the child into a practical plan relating to care at the time of death.
(www.togetherforshortlives.org.uk)

11.3 An advanced care plan can be used in conjunction with a care pathway, this assists the professionals in managing the process and supporting the child and their family, a care pathway can be accessed at https://www.togetherforshortlives.org.uk/resource/core-care-pathway/

11.4 Where there is a difference of views and wishes between the service user and their families, workers should escalate these to their manager and ensure this is documented in the relevant records.

12. Recording decisions about CPR

12.1 All decisions regarding not conducting CPR should be completed on the relevant form (Appendix E and F (Please note that the colour of the forms may vary between different geographical locations)), the form should be completed legibly in black ink. All sections of the form should be completed (Some documents maybe available online, so please familiarise yourself with its location).

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

- If the review box is full, a new form should be completed and the old form should be cancelled as above.

12.2 Capacity/Advance decisions: Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the service user's current circumstances.

12.3 Summary of the main clinical problems and reasons why CPR would be inappropriate unsuccessful or not in the service user's best interests.

12.4 Summary of communication with client/patient, their families/carers/immediate next of kin (where appropriate): State clearly what was discussed and agreed.

12.5 Summary of communication with service user/patient relatives or friends: If the service user does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the service user would decide if able to do so.

12.6 Members of the multi-disciplinary team: states names and positions, ensure that the DNACPR decision has been communicated to all relevant members of the healthcare team.

12.7 Healthcare professional recording this DNACPR decision: the service user's main medical lead (in the community setting it tends to be the GP, in the acute setting it will be their Consultant).

12.8 Review/endorsement: The decision must be endorsed by the most senior healthcare professional responsible for the service user's care at the earliest opportunity.

12.9 The Resuscitation Council UK recommends that:

- Paper forms on which CPR decisions are recorded should travel with the service user/patient at all times
- When a person is at home and has a current CPR decision (in particular a DNACPR decision) they understand and accept they should have with them a CPR decision form recording that situation
- If CPR decision forms are completed and/or stored electronically:
  a) They should contain all the required elements defined in this quality standard; they should be accessible immediately by all the organisations and individuals who may be involved in the service user's care

- There should be robust arrangements in place to ensure that they remain current and appropriate.

13. Confidentiality

13.1 Service users/patients with capacity have a right to make decisions about how their clinical information is shared.

13.2 Agreement/permission must always be sought where possible before sharing information with others, including family and friends.

13.3 Refusal by a service user/patient with capacity to allow information to be disclosed regarding DNAR/DNACPR order/ACP to family or friends must be respected.

13.4 Where service users lack capacity and their views on involving family and friends are not known, healthcare workers may disclose confidential information to those close to the service user where it is necessary to discuss the service user's care and is not contrary to the service users' interests.

13.5 The same principles of confidentiality for adults apply to children and young people. If a child/young person does not want to involve their parents every reasonable effort should be made to persuade the child/young person to involve their parents/guardians. Where the child/young person is not competent but does not want parental involvement, the GMC advises that when "it is necessary for the child's best interests for the information to be shared you can disclose information to parents or appropriate others".

14. Implementation Plan

14.1 For **consultation, ratification and dissemination** of this policy see the policy for drafting, approval and review of policies and SOPs; CORP10 Policy on Policies.

14.2 This policy will be implemented through:

- Communication of the policy to all relevant workers
- Communication of the policy to all stakeholders
- Raising awareness and understanding of the policy and related processes throughout the organisation through committee meetings, worker's meetings, Acacium Group pages, the website and general communication
- Through induction programmes and related training.

14.3 **Audit and Monitoring:**

14.3.1 Acacium Group will regularly audit its approach to resuscitation and for compliance with this policy and the relevant SOPs.

14.3.2 Processes for monitoring the effectiveness of the policy include:

- Audits of specific areas of practice
- Evidence of learning across the organisation Incident reporting procedure
- Appraisal and Personal Development Plan (PDP).

15. Associated Policies / SOPs

Policies

CLIN 06 Consent Policy
CLIN 07 Infection Prevention Policy
CLIN 08 Safeguarding Children Policy
CLIN 09 Safeguarding Vulnerable Adults Policy
CLIN 14 Health Records Management Policy
CLIN 19 Resuscitation Policy
CORP03 Whistleblowing for Internal Employees Policy
CORP04 Whistleblowing for Associate Workers and External Parties Policy
CORP11 Risk Management Strategy Policy
ORG 03 Health & Safety Policy

SOPs

Resus SOP 01 Adult Basic Life Support
Resus SOP 02 Paediatric Basic Life Support

Resus SOP 03 Recovery Position
Resus SOP 04 Adult Choking
Resus SOP 05 Paediatric Choking
Resus SOP 06 AED

16. References

- Decisions relating to cardiopulmonary resuscitation (2016) A joint statement from the British Medical Association (BMA) The Resuscitation Council UK (RCUK) and the Royal College of Nursing (RCN) www.resus.org.uk
- Withholding or withdrawing life sustaining treatment in children: A framework for practice (May 2004) Royal College of Paediatrics and Child Health
- Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice March 2015 – RCPCH https://adc.bmj.com/content/archdischild/100/Suppl_2/s1.full.pdf
- Treatment and care towards the end of life: good practice in decision making (May 2004) General Medical Council (GMC)
- Guidance on 'Do Not Attempt Resuscitation' (DNAR) Instructions (June 2010) United Kingdom Home Care Association Limited (UKHCA)
- Gold Standards Framework' https://www.goldstandardsframework.org.uk/what-are-gold-or-gsf-patients
- https://www.goldstandardsframework.org.uk/
- https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/
- https://www.nice.org.uk/guidance/ng61/resources/end-of-life-care-for-infants-children-and-young-people-with-lifelimiting-conditions-planning-and-management-pdf-1837568722885
- www.togetherforshortlives.org.uk
- https://www.togetherforshortlives.org.uk/resource/core-care-pathway/
- https://www.resus.org.uk/respect
- End of life care for adults: service delivery. NICE guideline [NG142] 16 October 2019 https://www.nice.org.uk/guidance/ng142
- https://compassionindying.org.uk/making-decisions-and-planning-your-care/planning-ahead/dnar-forms/

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla Part of Acacium Group	Ellea Nursing Part of Acacium Group	CHS Healthcare Part of Acacium Group
DUNN REGULATORY ASSOCIATES Part of Acacium Group		

Appendix B: Legislation

1. This Policy is based on the following legislation and national guidance as set out in the table below.

Legislation/Guidance	Description
Human Rights Act 1998	This Act incorporates the majority of rights set out in the European Convention on Human Rights into UK law. In order to meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention.
The Mental Capacity Act 2005	Provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. A service user who does not have the necessary mental capacity to take a treatment decision must receive treatment that is in their best interest.
Adults with Incapacity (Scotland) Act 2000	The guiding principles for The Adults with Incapacity Act 2000 states the Act must take account of: • The person's past and present wishes about their care and treatment • The care and treatment that will be of most benefit • The range of options available for care and treatment of the individual • The person's individual abilities and background • The person's age, gender, sexual orientation, religion, racial origin or membership of any ethnic group
UKHCA Factsheet: Guidance on "Do Not Attempt Resuscitation" Instructions (June 2010)	This guidance was designed to help homecare providers look at how to deal with "Do not attempt Resuscitation" Orders.
BMA. RCN RC (UK): Decisions relating to cardiopulmonary resuscitation (updated June 2017)	3rd Edition guidance identifies the key ethical and legal principles that should inform all CPR decisions.
Royal College of Paediatrics: Withholding or withdrawing life sustaining treatment in Children: A framework for Practice. (2004)	The framework is not a prescriptive formula to be applied in a rigid way in all cases but an attempt to guide management of individual cases with the fundamental aim to consider and serve the best interests of the child.
General Medical Council: Treatment and Care towards the end of life (2010)	This guidance provides a framework for good practice when providing treatment and care for service users who are reaching the end of their lives.
The Children's Act 1989	A statutory framework for the provision of children's welfare and services;

	• The child's welfare is paramount • Particular regard is paid to the wishes and feelings of the child • Children of sufficient maturity and understanding may be allowed to refuse medical examination/assessment
Children and Young People (Scotland) Act 2014	The Children and Young People (Scotland) Act 2014 covers topics that relate to consent of children and young people such as; parental responsibility, guardianship, court orders and the protection and supervision of children and young people.
The UN Convention on the rights of the child (1990)	Sets out fundamental principles which govern how children should be treated: • Article 3 – best interests of the child • Article 24 – Right to the highest obtainable standard of health and facilities • Article 13 – the child's right to freedom of expression • Article 12 – a child who is capable of forming their views
The Age of Legal Capacity (Scotland) Act 1991	The current position on consent in Scotland is broadly similar to England & Wales, with one important difference. Parents in Scotland cannot override a refusal of consent by a competent child. In Scotland a child under the age of 16 has the legal capacity to consent to his or her own treatment where, according to the Act when in the opinion of the qualified medical practitioner attending to him or her, he or she is capable of understanding the nature and possible consequences of the procedure or treatment. Age of Legal Capacity (Scotland) Act 1991, section 2 (4).
Decisions relating to Cardiopulmonary Resuscitation – Guidance from the British Medical Association, The Resuscitation Council and the Royal College of Nursing - 2016	Provide the latest guidelines to all establishments that face decisions about attempting cardiopulmonary resuscitation (CPR), including hospitals, general practices, care homes, hospices and ambulance services. It states that policies must be readily available and understood by all relevant staff and should also be available to the public.
Care Act 2014	The Act ensures that health and social services work together, helping people make informed choices about health and social care
Health and Social Care Act 2008 – revised 2012	The relevant part of this Act to the Policy is the introduction of the Care Quality Commission which is an integrated regulator for health and adult social care bringing together existing health and social care regulators under one regulatory body. The CQC has new powers to ensure safe and high-quality services.
Health & Safety at Work Act 1974	The Health & Safety at Work Act 1974 requires that all organisations with more than three staff have in place processes to promote the health and safety of their staff.
Control of Substances Hazardous to Health	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess

(COSHH) Regulations 2002	the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.

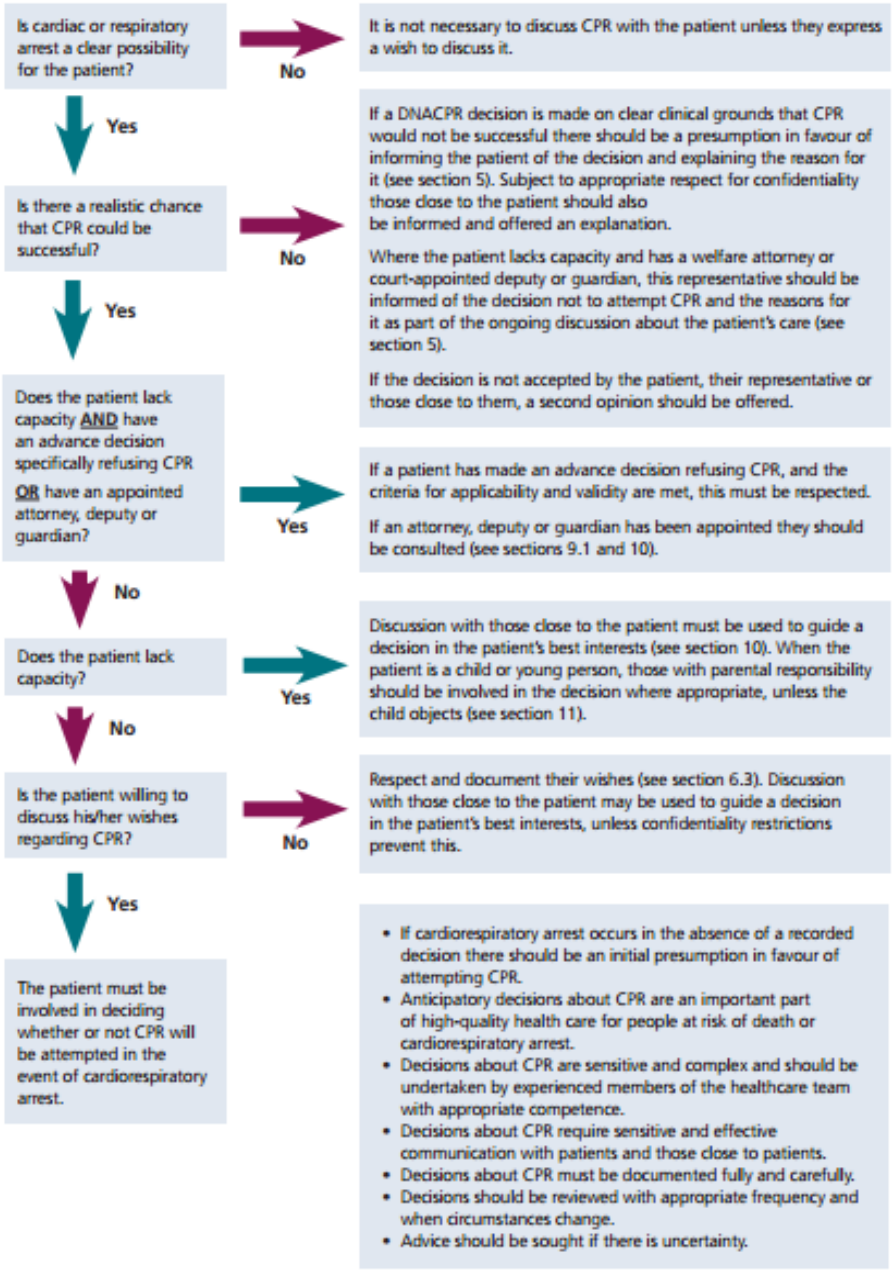
2. Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

3. Non-Discrimination

Any CPR or DNAR decision must be tailored to the individual circumstances of the service user. It must never be assumed that the same decision will be appropriate for all service users with a particular condition or in the same situation. Decisions must not be made on the basis or assumptions based solely on the factors such as the service user age, disability, or on a professional's view of a service user's quality of life.

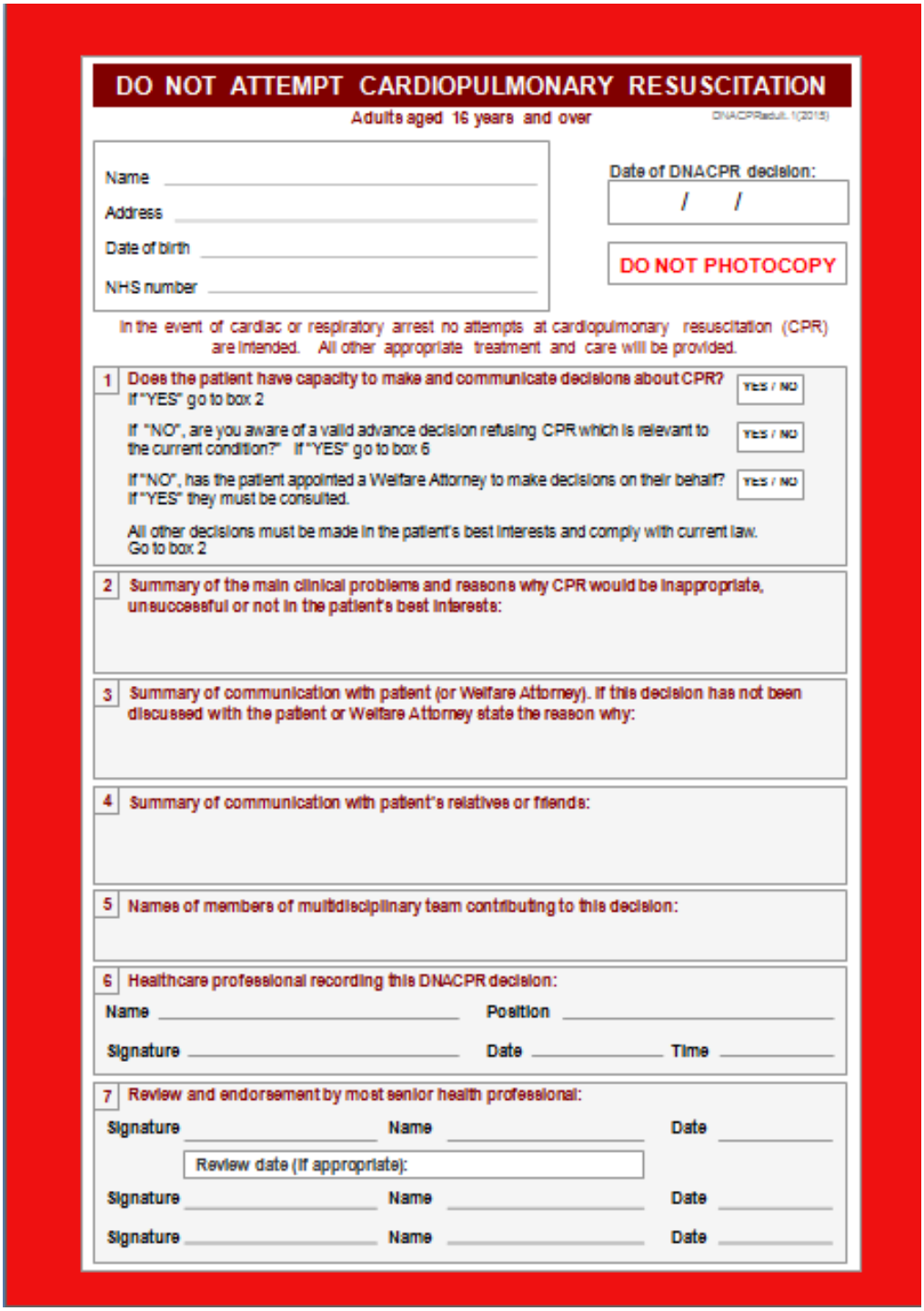
Appendix C: BMA, RCN, RCUK Decision Making Process



https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Appendix D: DNAR Form: Adult

Please note that the colour and format of the forms may vary between different geographical locations



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNACPRadult. 1(2015)

Name _____

Address _____

Date of birth _____

NHS number _____

Date of DNACPR decision: / /

DO NOT PHOTOCOPY

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

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

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

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

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

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

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

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

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

6 Healthcare professional recording this DNACPR decision:

Name _____ Position _____

Signature _____ Date _____ Time _____

7 Review and endorsement by most senior health professional:

Signature _____ Name _____ Date _____

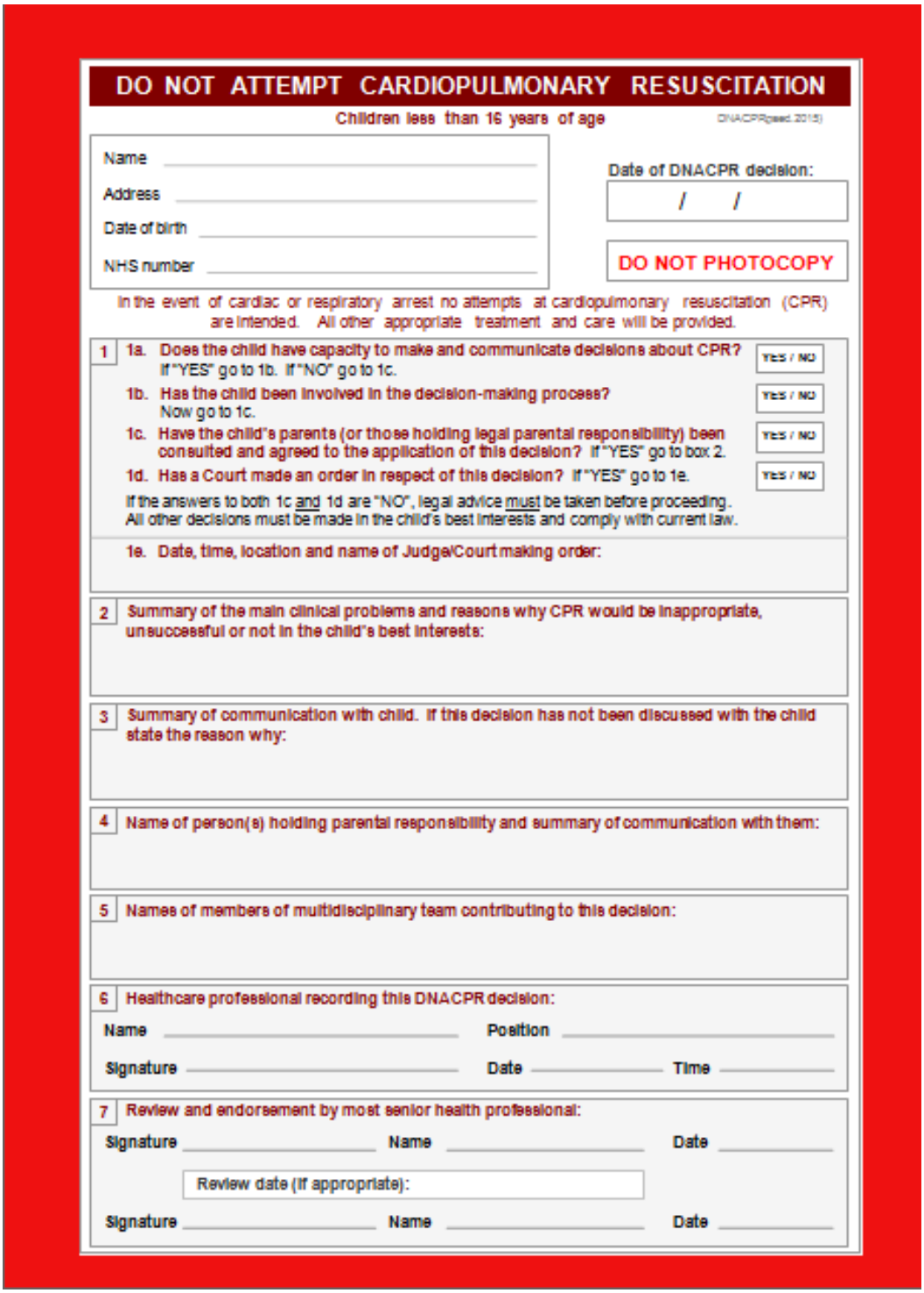
Review date (if appropriate):

Signature _____ Name _____ Date _____

Signature _____ Name _____ Date _____

Appendix E: DNAR Form: Child

Please note that the colour and format of the forms may vary between different geographical locations



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Children less than 16 years of age

DNACPRpaed.2015)

Name _____

Address _____

Date of birth _____

NHS number _____

Date of DNACPR decision: / /

DO NOT PHOTOCOPY

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

1 1a. Does the child have capacity to make and communicate decisions about CPR? If "YES" go to 1b. If "NO" go to 1c. YES / NO

1b. Has the child been involved in the decision-making process? Now go to 1c. YES / NO

1c. Have the child's parents (or those holding legal parental responsibility) been consulted and agreed to the application of this decision? If "YES" go to box 2. YES / NO

1d. Has a Court made an order in respect of this decision? If "YES" go to 1e. YES / NO

If the answers to both 1c and 1d are "NO", legal advice must be taken before proceeding. All other decisions must be made in the child's best interests and comply with current law.

1e. Date, time, location and name of Judge/Court making order:

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

3 Summary of communication with child. If this decision has not been discussed with the child state the reason why:

4 Name of person(s) holding parental responsibility and summary of communication with them:

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

6 Healthcare professional recording this DNACPR decision:

Name _____ Position _____

Signature _____ Date _____ Time _____

7 Review and endorsement by most senior health professional:

Signature _____ Name _____ Date _____

Review date (if appropriate):

Signature _____ Name _____ Date _____

Appendix F: ReSPECT Form

https://www.resus.org.uk/respect