East Midlands Ambulance Service NHS Trust

Emergency Care | Urgent Care | We Care

DNACPR AND ADVANCED DECISION TO REFUSE TREATMENT FOR PATIENT TRANSPORT SERVICES STANDARD OPERATING PROCEDURE

Links

The following documents are closely associated with this policy:

- End of Life Care Policy
- Clinical Management in End of Life Care Standard Operating Procedure
- Untoward Incidents Reporting Policy

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1.0	20 July 2016	25 July 2016	Clinical Governance Group	New SOP for EMAS Trust
2.0				
2.1				

Resuscitation Decisions in End of Life Care Standard Operating Procedure

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1. Introduction

1.1. East Midlands Ambulance Service NHS Trust is committed to providing high quality, safe and effective care to individuals approaching the end of their life.

1.2. The Trust recognizes that a patient approaching the end of life should be managed with dignity and respect; with their wishes adhered to wherever possible.

2. Objectives

2.1. The objectives of this procedure are to:

- Ensure that all patients with identified end of life needs receive safe and effective care in the most appropriate place, including preferred place of death where appropriate.
- Ensure that all patients approaching the end of life receive care within a legal framework and that staff are empowered to achieve this with confidence.

3. Scope

3.1. This procedural document applies to all Patient Transport Services staff attending a patient with end of life needs. It also applies to those involved in the booking and arranging of PTS activities within East Midlands Ambulance Service NHS Trust.

4. Definitions

4.1. **End of Life:** People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis of their condition
- life-threatening acute conditions caused by sudden catastrophic events.

4.2. **DNACPR: Do Not Attempt Cardiopulmonary Resuscitation:** a document that provides evidence that a patient should not receive CPR in the event of cardiopulmonary arrest (unless from an unrelated reversible cause for example choking).

4.3. **Advanced Care Planning:** A voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse treatment in specific circumstances.

4.4. **Advanced Decision to Refuse Treatment:** A legally binding decision to refuse specific treatment made in advanced by a person who has capacity to do so. This decision only applies at a time when that person lacks capacity to consent to, or refuse a treatment. If this involves refusal of life sustaining treatment it must be in writing, signed and witnessed and include the statement "even if life is at risk".

4.5. **Personal Resuscitation Plans:** These are care plans developed to detail the management priorities and limitations for individuals. These of typically used for the management of end of life care decisions in children and young people. They should be afforded the same consideration as a DNACPR document. This will be encompassed under the banner of DNAR for the purposes of this policy.

5. Responsibilities

5.1. **The Medical Director** is responsible for ensuring:

- This procedure is monitored and reviewed in line with current clinical guidance on an annual basis.
- Advice is provided to the Director of Workforce and Engagement on the requirements of training for all staff.
- Advice is provided to the Locality Management teams on the requirements for equipment

5.2. **Nominated Paramedic** is responsible for ensuring:

- That the procedure is current best practice and is updated as required and in the event of changes to best practice or identified risk.
- That advice is provided to all relevant roles within the trust and partner organisations.

5.3. **Director of People and Engagement** is responsible for:

- The provision of suitable end of life education and training for all staff as per the Trust's training needs analysis.
- The production of regular reports on training to include both attendance and non attendance in relation to end of life care elements.

5.4. **PTS Team Leaders are responsible for:**

- The dissemination of this procedure to operational staff
- Monitoring of performance against the requirements of this procedure

5.5. **Operational PTS Staff and PTS Control staff are responsible for:**

- Adherence to this procedure

- Raising concerns as per Trust Incident reporting procedure

6. Clinical Significance

6.1. Although every individual may have a different idea about what would, for them, constitute a 'good death', for many this would involve:

- Being treated as an individual, with dignity and respect
- Being without pain and other distressing symptoms
- Being in familiar surroundings
- Being in the company of those deemed to be close family and/or friends

6.2. A significant element within this is for the individual to die at their preferred place of death with dignity and respect.

6.3. However it is likely that in the care of the dying there may be a need for transport to and from healthcare facilities.

7. Identification of End of life Patients

7.1. **DNACPR** is a document that provides evidence that a patient should not receive CPR in the event of cardiorespiratory arrest (unless from an unrelated reversible cause for example choking).

- The presence of such documentation provides evidence that active treatment should not be provided in the event of cardiorespiratory arrest.

- **DNACPR key principles are shown in appendix 1.**

7.2. **Advanced Decision to Refuse Treatment** enables a person to refuse specified medical treatment in advance of a time where they may be unable to consent or refuse treatment following the loss of mental capacity. **Please refer to appendix 2 Advanced Decision to Refuse Treatment.**

8. PTS Booking Systems and DNACPR / ADRT - Healthcare Professional

8.1. All bookings MUST have a recorded DNACPR / ADRT status identified at the point of booking. In the event that a healthcare professional states that a DNACPR / ADRT is present it must be clearly stated on the booking information for the PTS resource. The knowledge of the patient and any escorts, in relation to the DNACPR must also be recorded.

8.2. In the event that an escort is also included in the booking, their knowledge of the DNACPR / ADRT must be confirmed.

8.3. DNACPR / ADRT patients will be categorised into the following bands, which will allow us to manage this important group of patients more effectively.

8.4. **Category 1: Those patients who are being transported to a location where death is imminent and may occur during transport.**

8.5. These patients need to be transported swiftly and responsively. These patients are to be booked on the day and transported individually within an agreed timeframe (or within appointment time).

8.6. DNACPR / ADRT status (signed by an appropriate **registered** clinician prior to transport) should be confirmed with PTS Control at time of booking and explicitly recorded.

8.7. Any individual who has a DNACPR / ADRT in place and it recognised as being in the last days / hours of life at the point of booking or collection MUST be transferred as a solo patient ONLY (excluding escorts).

8.8. **Category 2: Those patients who are clearly ill and need a clinical care en route.**

8.9. Whilst these patients have a valid DNACPR / ADRT order, their death may not be imminent, they may require a high level of Ambulance Care to cope with medical needs.

8.10. This group of patients' requirements are NOT suitable for Ambulance Care Assistant PTS resourcing and will be managed as per existing IFT arrangements or by a High Dependency Vehicle (clinician on vehicle).

8.11. **Category 3: Those patients who are not considered imminent or at risk of sudden deterioration with DNACPR / ADRT.**

8.12. These patients may be transferred with other patients.

8.13. Whilst these patients may have a DNACPR / ADRT in place, this is anticipated to be applicable further into the future than category 1 and category 2 above.

8.14. DNACPR / ADRT status (signed by the patient's doctor or appropriate registered clinician such as a specialist nurse prior to transport) should confirmed with PTS Control at time of booking and explicitly recorded.

9. PTS Booking Systems and DNACPR / ADRT - Private residence / Individual booking / Non-HCP referral

9.1. All bookings MUST have a recorded DNACPR / ADRT status identified at the point of booking. In the event that a DNACPR / ADRT is stated as present, it must be clearly stated on the booking information for the PTS resource. The knowledge of the patient and any escorts, in relation to the DNACPR must also be recorded.

9.2. It must be stated at the time of booking that the original form MUST be present for the PTS resource at scene. Failure to have this document available will mean that it cannot be adhered to. In the event of a patient identified as category 1 this will result in a potential refusal to transfer and normal admission procedure for a frontline resource will be used.

9.3. In the event of uncertainty over the validity of a DNACPR / ADRT document, advice must be sought via PTS control.

10. Initial PTS care contact

10.1. On arrival the patients' DNACPR / ADRT status MUST be confirmed via by either:

Original DNACPR / ADRT document available with the patient and completed appropriately. This MUST be available for ALL non HCP bookings. PTS control must be informed of verification of this form.

Or

Completion of the PTS transfer DNACPR Verification Form by a Registered authorised clinician PRIOR to transfer. (See appendix 3). This form will act as evidence of the existence of a valid DNACPR or ADRT for an individual. This form MUST be fully completed by a referring Healthcare Professional prior to conveyance. PTS Operations Centre MUST be informed and the document retained by EMAS.

11. Patient Deterioration in PTS Care (EXCLUDING CARDIORESPIRATORY ARREST)

11.1. In the event that a patient deteriorates, in a manner that has not been predicted, in the care of EMAS PTS an A&E ambulance MUST be requested immediately via 999.

11.2. In the event that the patient is being transferred and has been assessed as at significant risk of death in transit (death imminent) actions in the event of deterioration MUST be agreed prior to transfer.

11.3. First aid and basic life support should be provided as per training.

11.4. It must be remembered that a DNACPR does not mean do not treat.

11.5. Responsibility for care in this circumstance will transfer to the A&E resource upon their arrival.

12. Cardiorespiratory Arrest in PTS Care

12.1. In the event that a patient suffers a cardiorespiratory arrest CPR should not be commenced UNLESS there is evidence that the cause of the cardiorespiratory arrest is a reversible AND unrelated to the conditions of the DNACPR / ADRT i.e. choking.

12.2. In the event of cardiorespiratory arrest, PTS control MUST be informed AND 999 assistance requested. Following emergency resource intervention an individual may be conveyed by the PTS resource to the pre-agreed location as indicated on the DNACPR / ADRT transfer form.

12.3. In the event that there is no agreed conveyance site for such events, the nearest ED should be attended and the receiving hospital informed prior to arrival.

12.4. For patients identified for rapid discharge from Royal Derby Hospital who die in transit should be conveyed to the Royal Derby Hospital Mortuary. They mortuary must be informed by PTS control.

13. Consultation

13.1. These guidelines have been developed in conjunction with the East Midlands Clinical Advisory Group for End of Life which includes representation from across the East Midlands.

14. References/Bibliography

- Leadership Alliance for the Care of Dying People (2014) one chance to get it right. HMSO, London.
- Department of Health (2008) End of Life Strategy
- Joint Royal Colleges Ambulance Liaison Committee (2013) UK Ambulance Service Clinical Practice Guidelines
- National End of Life Care Programme (2012) Capacity, care planning and advance care planning in life limiting illness. NHS EOLCP, London.
- British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (2014) Decisions Relating to Cardiopulmonary Resuscitation 3rd ed.

15. Monitoring Compliance and Effectiveness

This policy will be reviewed through the Clinical Effectiveness Group and reporting on local and regional incidents. Further reporting will be undertaken by staff and service user feedback.

Appendix 1

DNACPR key Principles (For PTS staff)

Key Messages:

A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not to attempt CPR rests with the healthcare professionals responsible for the patient's immediate care.

Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

From "Decisions Relating to Cardiopulmonary Resuscitation 3rd ed." British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (2014).

How should a DNACPR directive be recorded?

There is no standard DNACPR form. Many Trusts will record the directive on a form specific for that purpose. However, a resuscitation directive can still be documented on a letter or as an entry in the patient notes.

How do I ensure a DNACPR is valid?

If staff are presented with a DNACPR it is reasonable to check that the DNACPR: is for the correct patient, and should be signed by the clinician making the DNACPR.

Should a DNACPR have a review date?

Many DNACPR forms will not have a review date. This is acceptable and indicates that the patient's condition is not expected to improve.

Can a DNACPR also apply to a child?

Yes. Often these will be in the form of a letter from the lead clinician setting down a detailed resuscitation care plan. The parents have usually been involved in this care. In some circumstances the plan may advise that a limited resuscitation takes place (e.g. bag and mask and chest compression only). Where at all possible a Patient Specific Protocol will be created.

Are there circumstances where a patient who has a DNACPR should still be resuscitated?

Occasionally a patient who has a DNACPR may suffer from a cardiac arrest from a clearly reversible cause such as opioid toxicity or choking. In these very rare occasions resuscitation should be considered as it is not within the foreseeable considerations of the DNACPR.

Should a patient with a DNACPR still be treated for other conditions?

Yes. A DNACPR purely relates to CPR and the patient should still receive treatment for any other condition. Therefore, it would be reasonable to discuss the most appropriate treatment with the patient and their medical team/ GP; these wishes may also be included within a care plan. It is important that conveyance to the Emergency Department is not the primary choice unless indicated.

Does the patient, or their relatives, need to agree a DNACPR?

Although there is no legal requirement for patients to consent to a DNACPR, usually where a patient has capacity they will be involved in the directive. Some patients may indicate that they do not wish to discuss resuscitation and in these cases the patient may not be aware of the DNACPR.

The only circumstances when a relative (or other adult who is not the patient) must be consulted in clinical directives is where a person has appointed a proxy with Lasting Power of Attorney (Health & Welfare) and subsequently lost their capacity to make their own directives. The extent of their directive-making capabilities depends on the scope stipulated in the LPA.

What is the difference between a DNACPR and an Advanced Decision to Refuse Treatment?

A DNACPR is simply a method of documenting the resuscitation component of a care plan and is a clinically led directive.
An Advanced Decision to Refuse Treatment is set out in law under the Mental Capacity Act 2005, which allows an individual to make directives regarding their care and treatment should they subsequently lose capacity. An ADRT can be about any component of a patient's treatment, not necessarily just resuscitation. Where an ADRT is for life-sustaining treatment the law requires that it is made in writing, signed and dated, and witnessed and should include the term "even if life is at risk".

Appendix 2

Advanced Decision to Refuse Treatment

What is an ADRT?

An ADRT enables a person to refuse specified medical treatment in advance of a time where they may be unable to consent or refuse treatment following the loss of mental capacity. It is not possible to make an advance *request* for treatment; however such information can be used to inform consideration of the patient's best interests.

Who can make an ADRT?

A person may make an ADRT if they:
- Are over 18 years old and,
- Have capacity at the time of making the ADRT.

Do you have to have an End of Life Care (EoLC) diagnosis to make an ADRT?

ADRT's are not exclusive to End of Life Care, however are commonly seen in these scenarios. In EoLC situations ADRT's are often created to deal with resuscitation directives and it is essential to ensure that ADRT's which relate to life-sustaining treatment fulfil the legal requirement stipulated by the Mental Capacity Act 2005. It is reasonable to commence resuscitation whilst the facts of an Advance Directive are established.

Can an ADRT be made verbally?

Only where the treatment being refused does not constitute a life-sustaining treatment.

What if the ADRT is for Life-Sustaining Treatment?

The Mental Capacity Act 2005 stipulates that for an Advance Directive to be applicable for life-sustaining treatment it **must** meet the following criteria:

a) It must be in writing.

b) Where an ADRT is for life-sustaining treatment the law requires that it is made in writing, signed and dated, and witnessed and should include the term "even if life is at risk".

c) It must specify the treatment being refused; this can be written in layman's terms.

d) It must be signed by the patient or another in their presence if they are unable to sign it themselves.

e) It must be witnessed.

It has been established in case law that these criteria **must be met in full** for the Advance Directive/ADRT to be valid in law[1].

[1] See *An NHS v D [2012] EWHC 885 (COP)*

When is an ADRT *not* valid?

An ADRT is not valid if the patient:
a) Has withdrawn the directive at a time when s/ he has capacity to do so;

b) Has, under a Lasting Power of Attorney created **after** the ADRT was made, conferred the authority to a donee (or donees) to give or refuse consent to the treatment to which the ADRT relates, or

c) Has done anything else clearly inconsistent with the advance directive remaining his/ her fixed directive.

The patient has a DNACPR directive, but doesn't have an ADRT. Does that mean the patient has not been consulted?

Not necessarily. A DNACPR directive is a treatment directive taken in advance by a clinician. An ADRT is a refusal of treatment made in advance by the patient. The creation of an ADRT may be made for many personal reasons. ADRT's, where valid and applicable, like contemporaneous refusals of treatment should be respected regardless of whether the clinician understands or agrees with the patient's directive or their rationale.

What is the relationship between ADRT's and Lasting Power of Attorney?

If an ADRT is made, and subsequently the patient confers the authority to make the refusal specified in the ADRT to a donee under the Lasting Power of Attorney - Health and Welfare (LPA) the ADRT is no longer valid. Here, the LPA supersedes the Advance Directive. However, if the patient creates and registers a donee under Lasting Powers of Attorney, and subsequently makes an Advance Directive then the Advance Directive is valid. Essentially, the more contemporary of the two tools should be used. It is important to remember that Advance Directives are only applicable for the treatment specified.

When is an ADRT *not* applicable?

An ADRTis not applicable to the treatment in question if:
a) At the material time the patient has capacity to give or refuse consent to it;

b) The treatment is not the treatment specified

c) Any circumstances specified are absent, or

d) There are reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of the ADRT and which would have affected his directive had s/ he anticipated them.

If there is any uncertainty about the validity or applicability of an ADRT then clinical advice should be sought. In some cases, the Court of Protection will be required to intervene. Whilst advice is being sought, nothing in the ADRT should prevent the provision of life-sustaining treatment or treatment to prevent deterioration.
An invalid ADRT may still provide information which enables clinicians to assess a person's best interests if they have reasonable grounds to think it is a true expression of the person's wishes. In such circumstances, staff on scene should follow National Clinical Guidelines and seek clinical support.

Appendix 3

PTS Transfer DNACPR Verification Form

Non-Emergency Patient Transport Services DNACPR Authorisation Form

This form is only to be used when a patient has a valid DNACPR that will not travel with the patient

Patient Name:		**Patient NHS Number**	
Transport reference number/booking number		**Please circle relevant DNACPR status**	**Imminent** **Not imminent**

To be completed by authorising clinician only

What is the patients's medical condition?	
What is the palliative status	
Where is the patient going?	
What is the reason for travel?	
Confirm that there is a current, valid DNAR for the patient (this should be shown to the ambulance crew or record reason for not shown)	
Does the patient have a valid advanced decision to refuse treatment? If so what is this for?	
Are there any other records of the patients or relatives wishes for the comfort of the patient during transport?	
Does the patient have a lasting power of attorney for health and welfare? If yes provide details.	
What supportive measures can be given?	
If the patient dies what is the agreed location for conveyance? (note- this will be the nearest ED in the event of no planned destination)	

I confirm that I am authorised to provide the information above and that it is correct. I confirm that the patient has a current and valid DNACPR or ADRT (please delete as appropriate). This has been explained to the ambulance crew.

Name of clinician (print)		**GMC / HCPC/ NMC number**	
Signature		**Contact details for clinician**	
Hospital/location		**Ward/Unit**	