# Do Not Attempt Cardiopulmonary Resuscitation reminder for GPs

The following is intended as an aide memoir for General Practitioners in Calderdale. For more info see: - [Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing](https://www.bma.org.uk/media/1816/bma-decisions-relating-to-cpr-2016.pdf). The Adult Safeguarding Team at the CCG is also happy to advise.

* DNACPR decisions are best considered as part of wider advanced care planning for people nearing the end of life, or at risk of cardiorespiratory arrest. In addition, since Covid, it is now suggested that we have these conversations with people with stable co-morbidities with whom we would not previously have raised these issues. (<https://www.nice.org.uk/guidance/ng165/chapter/2-Treatment-and-care-planning>) ​
* DNACPR decisions must consider individual circumstances and should never be dictated by “blanket” policy.
* **Always Record: - Patient’s Capacity, willingness to discuss CPR and details of the conversation with person.**
* **CPR decisions should always be discussed with the person except when it would cause psychological harm. If this decision was not discussed with the person, record the reason(s) why this was inappropriate (there must be an initial presumption of involving the person in the decision).**
* A DNACPR decision is only about CPR and does not mean stopping any other treatment/support.
* If it is decided that death is inevitable, and CPR would not re-start the heart and breathing for a sustained period, the clinician should make a DNACPR decision. The person\* should be informed of this. They\* have the right to request a second opinion. (\* or those close to the person where they lack capacity).
* Where CPR may be successful, the person\* must be involved in the DNACPR decision.
* It is important to ensure that, where capacity is lacking, and in the absence of an applicable Power of Attorney or Court-Appointed Deputy or Guardian, those close to the person understand that they are not the final decision-makers, but that they have an important role in guiding the healthcare team towards a “best interests” decision.
* If someone has made formal Advance Decision to Refuse Treatment which includes refusing CPR, and which is valid\*\* and applicable\*\* to the circumstances, then CPR must not be attempted. (\*\* more info: - <https://compassionindying.org.uk/making-decisions-and-planning-your-care/planning-ahead/advance-decision-living-will/legally-binding-advance-decision/>).
* If the patient lacks capacity and there is no one to consult, then an Independent Mental Capacity Advocate (IMCA) must be involved – contact Cloverleaf. (<https://www.cloverleaf-advocacy.co.uk/offices/calderdale>).
* Any change in the patient’s condition should trigger a review of the DNACPR decision.
* A DNACPR decision must be communicated to all those involved in the person’s care and the DNACPR form should travel with the person when moving home / hospital.