"Sharing and Involving"

A Clinical Policy For Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults In Wales

Revised Policy: Version 3 July 2017

DNACPR Form (Adult) DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) DISCUSSION

Date of DNACPR Discussion:	/ /	
Date Reviewed	/ /	
Reviewed by		
(Signature/GMC No)		

Surname:
First Name:
NHS/Hospital No:
Date of Birth:
Home Address:

WHILST ACTIVE, THIS FORM **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. **Does the patient have capacity to make and communicate decisions about CPR?** YES / NO
   If "NO"
   Are you aware of a valid Advance Decision to Refuse Treatment refusing CPR which is relevant to the current condition?" YES / NO
   Has the patient appointed a Health & Welfare Attorney to make decisions on their behalf? YES / NO
   If "YES" they must be consulted.

2. **Summary of the main clinical conditions and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: Tick all reasons that apply.**

   Clinical Summary:

   Reasons:
   Not in the best interest/harm from CPR>benefit ☐ This is a natural anticipated and accepted death ☐
   Patient refused CPR ☐ Other (please elaborate in patient's healthcare record) ☐

3. **Has a discussion taken place with the patient?** YES / NO
   If CPR has NOT been discussed please clearly record reasons in the box below:

4. **Has appropriate discussion taken place with those close to the patient, a Health and Welfare Attorney or an IMCA?** YES / NO

   Name of person: ..... Relationship to patient:.....

5. **Healthcare Professional completing this form:**
   (Document is ONLY active when signed, timed and dated with GMC No.)

   Name (PRINT): ..... Position: .....
   Contact Details: ..... GMC No: ..... **or** NMC No: .....
   (Nurse – form NOT active unless countersigned in box 6)

   Signature: ..... Date: ...../...../..... Time:.....

6. **Senior Responsible Clinician with oversight to sign below:**
   (Must inform MDT/others involved in the care of the patient of the decision – record the communication below)

   Name (PRINT): ..... Position: .....

   Contact Details: ..... GMC No: .....

   Signature: ..... Date: ...../...../..... Time:.....

7. **CANCELLATION of decision: NB: Cross form CLEARLY and write "CANCELLED" across form – notify ALL copy holders (see details below)**

   Name (PRINT): ..... Position: .....

   Contact Details: ..... GMC No: .....

   Signature: ..... Date: ...../...../..... Time:.....

8. **COPIES of this DNACPR decision form have been sent to:**

   1. ☐ **Patient /Carer**
   2. ☐ **GP**
   3. ☐ **Nursing or Care Home**