This is NOT A LEGAL DOCUMENT. This form recommends ALLOWING NATURAL DYING only in the event of CARDIORESPIRATORY ARREST

DNACPR

NHS

- **If this person's heart and breathing stop, cardiopulmonary resuscitation (CPR) should NOT start, and they should be allowed to die in a natural and dignified way, wherever possible.**
- **This form does NOT stop healthcare teams from taking any appropriate and desired action to fix reversible health problems and prevent deterioration.**
- **This form protects this person from inappropriate or unwanted CPR attempts.**

Name: **NHS no:**

Date of Birth: **Place where decision made:**

EITHER

☐ **There is no realistic chance that CPR could be successful / A medical decision has been made that CPR would not work.**

CPR is not an available treatment: **you must clearly document why**. There is still a **legal requirement** to explain this decision to this person and those important to them wherever appropriate (see *DISCUSSION/EXPLANATION*). Although this is a decision made by the clinical team and not the person in this case, this person is entitled to a second opinion where they disagree (unless the decision was made by a multi-disciplinary team).

OR

CPR is a treatment which MIGHT work, but should not be attempted because...

☐ This person has capacity, and has decided that **they would not want attempted CPR** (ADRT is advised).

☐ This person lacks capacity and has a **valid and applicable** ADRT or Court Order refusing attempted CPR.

☐ This person lacks capacity, and the 2005 Mental Capacity Act **Best Interests** decision, is not to attempt CPR.

☐ This person lacks capacity and **a legal proxy* has made this decision** (LPA Health and Welfare attorney).

☐ This person is a child. The DNACPR decision was made involving a **person with parental responsibility**.

** Next-of-Kin has no legal standing and is NOT the same as a legal proxy. NOK may inform Best Interests decisions but cannot consent/decide for the patient*

DISCUSSION/EXPLANATION AND DOCUMENTATION

This decision HAS been discussed with (or explained to) ...

☐ **The person** ☐ **Those important to the person** (e.g. family, carers) **or patient's legal proxies**

Please specify .....

The decision HAS NOT been discussed with (or explained to) ...

☐ **The person**, because they have capacity and have dissented to discussion

☐ **The person**, because they cannot partake in meaningful discussion (You must still attempt discussion with others)

☐ **The person**, because discussion is likely to result in physical or psychological **harm** to them

☐ **The person**, because they lack capacity, and **their legal proxy has been consulted** on this decision

☐ **Family/carers/important others**, because the person has capacity and has not given consent for discussion

☐ **Family/carers/important others**, because they are missing, absent, or uncontactable

FOR DECISION & DISCUSSION DETAIL, SEE NOTE LOCATION: .....

This form is valid when signed. Digital signatures are permitted. The authorised **healthcare professional** is defined by local policy and may be any professional who has received adequate training or instruction in communication around DNACPR decisions. Wherever possible it should be the most senior responsible professional for this person's care. Where this is not the case, the most senior professional should be notified of this form's completion as soon as reasonably possible, and according to any local Trust policy. **This is an advisory form which does not expire** but should be reviewed at available opportunities, whenever this person's condition changes, or at this person's/clinician's request.

Optional: If death in transit anticipated, ambulance service please: ☐ *Continue* to original destination ***OR*** ☐ *Return* to journey start.

HEALTHCARE PROFESSIONAL

Signature	
Date	
Name (print)	
Role	
Registration #	

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Form developed by the NHS *NENC Deciding Right* group. **Ver. 18 (Print-Ready Build PDFJP03):** adapted with stakeholder input 2025-2026.

Decision-Making Framework

Anticipatory decisions about CPR are an important part of high-quality health care for people at risk of death or cardiorespiratory arrest.

Is cardiac or respiratory arrest a clear possibility for the patient?

NO → **It is not necessary to discuss CPR with the patient unless they express a wish to discuss it, or local healthcare structures require proactive discussions.**

YES

Is there a realistic chance that CPR could be successful?

NO → **The DNACPR decision has been made on medical grounds**; there is no requirement for patient *consent* or *involvement* in making this decision, **but there is still a legal obligation** to *inform* a patient (with capacity to engage) of the DNACPR decision and explain the reason(s) for it, unless doing so is likely to cause **physical or psychological harm** to that patient. Distress alone is **not** a suitable reason to avoid discussion. Those close to the patient should also be informed and offered explanation, unless a patient's wish for confidentiality prevents this. Reason(s) for making a DNACPR decision on medical grounds should be clearly recorded in the patient's notes (avoiding legally ambiguous terms like 'futility'). If the decision is not discussed, you must clearly document why (e.g. in relation to anticipated **harm**, or if the patient dissented to discussion with themselves or others). Where a patient lacks capacity and has a welfare attorney or court-appointed deputy or guardian, this representative should be **informed** of the decision not to attempt CPR and the reasons for it, as part of the ongoing discussion about the patient's care. Where a patient lacks capacity, the decision should be explained to those close to the patient without delay. If this is not done immediately, the reasons why it was not practicable or appropriate must be documented. Remember that there is no provision in UK law whereby a patient or representative may demand a treatment that is deemed clinically inappropriate. If however the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered (but no obligation exists to do so where the decision was made by a multi-disciplinary team).

YES

Does the patient lack capacity AND have an advance decision specifically refusing CPR OR have an appointed attorney, deputy or guardian?

YES → If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, this is legally-binding and must be respected. If an attorney, deputy or guardian has been appointed they must be consulted on any CPR decision if an arrest is a possibility.

NO

Does the patient lack capacity?

YES → Discussion with those close to the patient must be used to guide a decision in the patient's Best Interests. When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate, unless the child objects. Those close to the patient help **inform** a decision, based on their understanding of what the patient themselves would have wanted – they **do not make the decision**: The MCA statutory Best Interests processes must be followed.

NO

Is the patient willing to discuss their wishes regarding CPR?

NO → Respect and **document** the patient's refusal to discuss this. Discussion with those close to the patient may be used to guide a decision in the patient's Best Interests, unless confidentiality restrictions prevent this. Seek patient consent to discuss with others. Be clear that refusal to discuss CPR will be respected but will not prevent healthcare teams from making decisions in their Best Interests if needed.

YES

Shared decision-making: The patient must be involved in deciding whether CPR would be attempted in the event of cardiorespiratory arrest

- **If cardiorespiratory arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting CPR.**
- **Decisions about CPR are sensitive and complex and require sensitive and effective communication with patients and those close to them by experienced and competent healthcare team members.**
- **Decisions about CPR must be documented fully and carefully.**
- **Decisions should be reviewed with appropriate frequency and when circumstances change.**
- **Advice should be sought if there is uncertainty.**
- **Do not delay time-critical DNACPR decisions if you have exhausted all practicable steps to have relevant conversations contemporaneously (including by telephone or out-of-hours). Document this, and make plans to undertake discussions as soon as possible, but do not subject a patient to inappropriate CPR attempts if conversations are just not possible.**

Adapted from BMA, Resuscitation Council, (UK), Royal College of Nursing, Decisions relating to cardiopulmonary resuscitation, 3rd Edition, 2016.