

**Southern Health and Social Care Trust**

**Acute Directorate**

***'Do Not Attempt***

***Cardiopulmonary Resuscitation'***

**(DNACPR) Procedure for Adults**

**(aged 18 years and above)**

**Procedure Checklist**

<b>Name of Procedure:</b>	
<b>Purpose of Procedure:</b>	
<b>Directorate responsible for Procedure:</b>	
<b>Name &amp; Title of Author:</b>	
<b>Does this meet criteria of a Procedure?</b>	
<b>Trade Union consultation?</b>	
<b>Equality Screened by:</b>	
<b>Date Procedure approved by Resuscitation Committee:</b>	
<b>Members of Resuscitation Committee in Attendance:</b>	
<b>Procedure Approved/Rejected/ Amended</b>	
<b>Policy Implementation Plan included?</b>	
<b>Any other comments:</b>	
<b>Date presented to SMT</b>	
<b>Director Responsible:</b>	
<b>SMT Approved/Rejected/ Amended</b>	
<b>SMT Comments</b>	
<b>Date received by Employee Engagement &amp; Relations for database/Intranet/Internet:</b>	
<b>Date for further review</b>	

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## **1.0 Introduction:**

### **Definition of DNACPR**

***The term ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) indicates that in the event of cardiopulmonary arrest neither basic nor advanced resuscitation will be instigated.***

1. A DNACPR decision applies solely to CPR; simple basic first aid will still be carried out as appropriate (e.g. placing the patient in the recovery position, clearing the airway of food or vomit, etc). All other treatment options will not be influenced by a DNACPR decision.
2. A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the patient’s respiratory or cardiac arrest that does not match the circumstances envisaged.
3. A DNACPR decision must be recorded in the patient’s medical notes and signed by a senior clinician and/or their deputy at all times.
4. DNACPR orders must be made in conformity with this policy, which includes the completion of a Trust DNACPR form

**NB:** Due to the nature of the interventions carried out in the Intensive Care Unit (ICU) setting, decisions regarding resuscitation will usually be made in conjunction with decisions concerning withdrawal or limitation of supportive therapy. Therefore, an ICU-specific procedure is to be referred to in these circumstances. This procedure is based on the CCaNNI ‘Guidance for end of life care’.

### **1.1 Purpose of the Procedure:**

The purpose of this procedure is to provide guidance for all relevant staff working within the Acute Directorate regarding the process of **making, recording and reviewing** Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

### **1.2 Scope of the Procedure:**

This procedure applies to all medical staff and other members of the multidisciplinary team who are involved in the process of making, recording and reviewing DNACPR orders within the Acute Services Directorate. This procedure applies to those aged **18yrs and above**

## **2.0 The Roles and Responsibilities:**

1. **All staff** have a responsibility for ensuring that the principles outlined within this document are universally applied.
2. **Director of Acute Services** is responsible for ensuring that the procedure is disseminated, implemented and audited in the appropriate clinical areas across the directorate.
3. **Associate Medical Directors** are responsible for ensuring compliance with this procedure, national clinical, professional and legal guidelines and promoting best practice in line with this procedure within their teams.
4. **Consultant Doctors / Staff Grades / Associate Specialists** are responsible for compliance with this procedure in the decision making relating to resuscitation, any discussions with patient and family in line with this procedure and the accurate and complete recording of DNAR or escalation status of patients.
5. **Doctors in Training are required to** understand the implications of this procedure and their role in decision making relating to resuscitation, any discussions with patient and family in line with this procedure and the accurate and complete recording of DNAR or escalation status of patients.
6. **Registered Nurses and Midwives** are responsible for ensuring sharing of any resuscitation or escalation of treatment decisions across multi-disciplinary team within individual wards or departments and sharing decisions supported by documentation when patients are required to attend or receive treatment in other departments within the organisation.
7. **Resuscitation Leads** are responsible for auditing all CPR attempts and assessing what proportion of patients should have had a DNACPR decision in place and to prepare a three monthly report for tabling at the Resuscitation Committee.
8. **Resuscitation Committee** are responsible for reviewing this procedure yearly within the context of national clinical, professional and legal guidelines. To consider the outcomes and recommendations of audits relating to DNACPR and provide a 3 monthly report to the Acute Directorate Governance Forum on audit findings.

### **3.0 DNACPR Decision-Making**

A decision that CPR will not be attempted, on best interest grounds because the burdens outweigh the benefits to the patient, should be made only after consideration of all relevant factors. A decision-making framework taken from this BMA/RC (UK)/RCN document is included at the end of this procedure to assist with decision making. **Appendix 1**

Factors influencing a decision not to attempt resuscitation should include:

1. The likely clinical outcome, including the likelihood of successfully restarting the patient's heart and breathing and the level of recovery that can realistically be expected after successful resuscitation.
2. The burden of resuscitation outweighs any possible benefit.
3. Death is expected imminently as a natural progression of the disease process.
4. Where resuscitation is not in accord with a valid and applicable advance directive.
5. Where resuscitation is not in accord with the patient's known or ascertainable wishes or their previously expressed views, feelings, beliefs and values.

Should a patient be unable to make their wishes known, a valid advance directive i.e. an anticipatory refusal or 'Living Will', giving informed and competently made instructions that relates to the circumstances which have arisen, is likely to be legally binding. Some patients choose to express their wishes in a written document but it is not necessary for refusal to be in writing in order to be valid. Where a competent patient has expressed a clear and consistent refusal, this is likely to have the same status as a written advance directive.

### **3.1 Discussions with Patients and/or Relevant Others about DNACPR**

Discussions about resuscitation are sensitive and complex and should be undertaken by experienced medical and nursing staff.

The timing and nature of discussions about resuscitation are a matter of judgement for the clinical team. Such discussions can result in upset and even anger from patients and their families and are often uncomfortable for healthcare team but anticipation of this should not prevent open and honest communication, especially where these discussions need to take place due to deteriorating health that may indicate the patient is dying and CPR would not prevent death"

Information should be provided in a manner and format which the patient understands; this may include the need for an interpreter.

The main purpose of discussions is to elicit what the patient's views are or would be if they were able to express them.

In these circumstances, it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient, but to help the healthcare team to make an appropriate decision in the patient's best interests. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision-making but that they cannot insist on a treatment or on withholding or withdrawal of a treatment.

Issues for discussion should include the following:

1. The nature of the patient's condition including burden of disease and the nature of the patient's illness.
2. The likely course of underlying conditions and prognosis for life and distress/pain.
3. The therapeutic options in the absence of a DNACPR order.
4. The likely outcome and course of attempted resuscitation including intubation, ventilation, the possibility of successful outcomes.
5. A recognition that at times it is better not to intervene and that DNACPR is not unethical.

### **3.2 *Involvement of Adult Patients, with capacity, in Decision-Making Process***

Competent patients should be involved in discussions about attempting CPR unless they indicate that they do not want to be. A competent adult's decision to refuse CPR must be respected.

A DNACPR decision will usually only be made after discussion with the patient and/or their relevant others. Any discussion with the patient or their relevant others regarding resuscitation must be documented on the appropriate Trust DNACPR form.

It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer cardiopulmonary arrest. If, however, a patient does require CPR and the outcome is successful, discussions about the possibility of future resuscitation should take place, if appropriate.

If the discussions about resuscitation would be unnecessarily burdensome for the patient or they do not have capacity to make decisions, the decision not to resuscitate shall be made using a multi-disciplinary team approach, with the best interests of the patient as the only objective. The views of any relevant others should be taken into account, where possible. However, it must be understood that, in the case of an adult, no other person apart from the patient can give or refuse consent to treatment.

The overall responsibility for decision-making rests with the consultant in charge of the individual patient's care. In the absence of the treating consultant/ an appointed medical deputy may make decisions.

In palliative care or where attempted CPR is likely to be futile, any discussion with the patient and/or their relevant others may primarily be about allowing a natural death and clinicians explaining that resuscitation is unlikely to work or be of benefit.

In circumstances in which it is not possible or appropriate to discuss CPR with a patient and/or their relevant others, the DNACPR form must still be completed indicating the reasons why these discussions were not appropriate

Patients may when appropriate be offered relevant written information regarding resuscitation and the meaning of DNACPR.

### **3.3 *Involvement of Adult Patients, who lack capacity, in Decision-Making Process***

Adults should be assumed to have capacity unless there is clear evidence to the contrary. A person is regarded as legally unable to make a decision for themselves if they are unable to do any of the following:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision, or
- communicate their decision (whether by talking, using sign language, visual aids or by other means).

Where a patient has not made an advance decision, the treatment decision rests with the most senior clinician responsible for the patients care. Whilst there is no statutory provision for decision-making, for Northern Ireland, for people who lack capacity, it is nonetheless good practice to discuss decision-making with those close to the patient in order to determine what would be in the best interests of the patient. (Decisions relating to cardiopulmonary resuscitation – Guidance from the BMA, RC (UK) & RCN, Oct 2014)

### **3.4 *Recording a DNACPR Decision***

Attempted resuscitation will be commenced on all patients undergoing cardiopulmonary arrest unless a DNACPR order is recorded. A decision not to resuscitate must be recorded in the medical notes as soon as possible after admission, stating the reasons for the decision. If the patient was not consulted this should also be recorded, together with the reasons for not having done so. Specific forms are available for recording DNACPR decisions.

The DNACPR decision must be recorded on a Trust DNACPR form, **see Appendices 2 and 3** for sample forms. **After the form is completed it must be filed inside the front cover of the patient's current medical notes** with a brief reference in the current admission notes, using black ink and capitals. This decision must be communicated to the Nurse in charge of the ward immediately it has been agreed

The resuscitation decision will be recorded in the nursing care plan by the nurse to whom the DNACPR decision has been communicated.

In circumstances where the DNACPR order is made by the most senior doctor immediately available, it should be reviewed and endorsed by the consultant responsible for the patients care within 24 hours.

When a DNACPR order is in place for the patient, this should be communicated to the GP on the patient's discharge and the decision should be reviewed by the GP.

### **3.5 Review of a DNACPR Decision**

A completed DNACPR Form in the medical records is to be regarded by all staff as the current authoritative statement. It is therefore imperative that this record is reviewed and kept up-to-date.

The DNACPR order must be reviewed, at an interval which is appropriate in the individual case, and particularly if there is a significant change in the clinical condition of the patient. All reviews should be recorded on the DNACPR form.

On occasions when a DNACPR order is cancelled, the form should be lined-through in ball-point pen with two diagonal lines and the word **CANCELLED** written clearly between them. The review section should be signed and dated by the senior doctor/consultant cancelling the order. The reasons for reversal of the decision should be recorded in the patient's records and **the DNACPR form removed from the inside front cover and filed in the body of the notes.**

The clinician making or cancelling a DNACPR order is responsible for ensuring that a registered nurse on the current shift is informed of this decision. The nurse informed must record the decision to cancel the DNACPR in the patient's Nursing Care Plan. It is the responsibility of the nurse to make known the resuscitation status of the patient to staff taking over their care, and the reasons for that decision.

### **3.6 The Peri-operative (during surgery) Management of Cardiorespiratory Arrest in Patients with a Valid DNACPR Order in Place**

All treatments should be in the best interests of the patient. If possible, get the patient's views before coming to theatre on the management of easily treatable and common situations e.g. heart going slow during surgery. Record in the hospital notes the patient's wishes on the treatment of irregular heart rhythms during their surgery.

Unless otherwise stated by the patient, irregular heart rhythms during their surgery should be treated if they are felt to be largely secondary to the surgery or anaesthesia e.g. as a result of high carbon dioxide levels, laparoscopy (investigation in abdomen using gases to inflate the abdomen, drugs, electrolyte abnormalities).

Life threatening heart rhythms secondary to other causes e.g. IHD, PE, may be left untreated.

Apnoea (stopped breathing) secondary to drugs should be treated.

CPR can be commenced for a short period of time in order to treat the problem e.g. to administer drugs e.g. atropine in the presence of profound bradycardia (slow heart rhythm or asystole (heart stops) secondary to a vagal stimulation).

In the recovery room it is less likely that arrhythmias will be directly related to anaesthesia and surgery therefore it is probably in the best interest of the patient that the DNACPR order is followed in the recovery room.

### **3.7 *The Management of a Patient with a Medical Assisted Device in Place***

Where a patient has a medical assisted device in place i.e. Implantable Cardioverter / pacemaker and a DNACPR decision has been made this device should be deactivated to avoid unnecessary discomfort or distress to the patient. If the device is not deactivated it will continue to function as normal and treat any abnormal heart rhythms which will prevent the natural course of events at the time of death.

### **4.0 *Transfer to another Hospital Within the Trust or to a Residential or Nursing Home***

A current DNACPR order will ***not*** automatically be revoked on patients transferred to another hospital within the Trust. It will be the responsibility of the admitting doctor to review the decision. In the case of emergency referrals, the initial decision will be made by the admitting doctor following consultation with the ward team, the referring doctor and the patient (or their next-of-kin if the patient is unable to make their wishes known) and confirmed with the responsible Senior Doctor /consultant at the next ward round.

When patients who have had a DNACPR order in hospital are being transferred to a Nursing Home, this information should be notified to the staff in the transfer documentation.

It is the responsibility of the GP who is taking over the patient's medical care to review the DNACPR within 48 hours of discharge. If staff have any concerns regarding the patient's resuscitation status prior to review by the GP, he/she should contact the patient's GP or the Out-of-Hours Doctor for guidance.

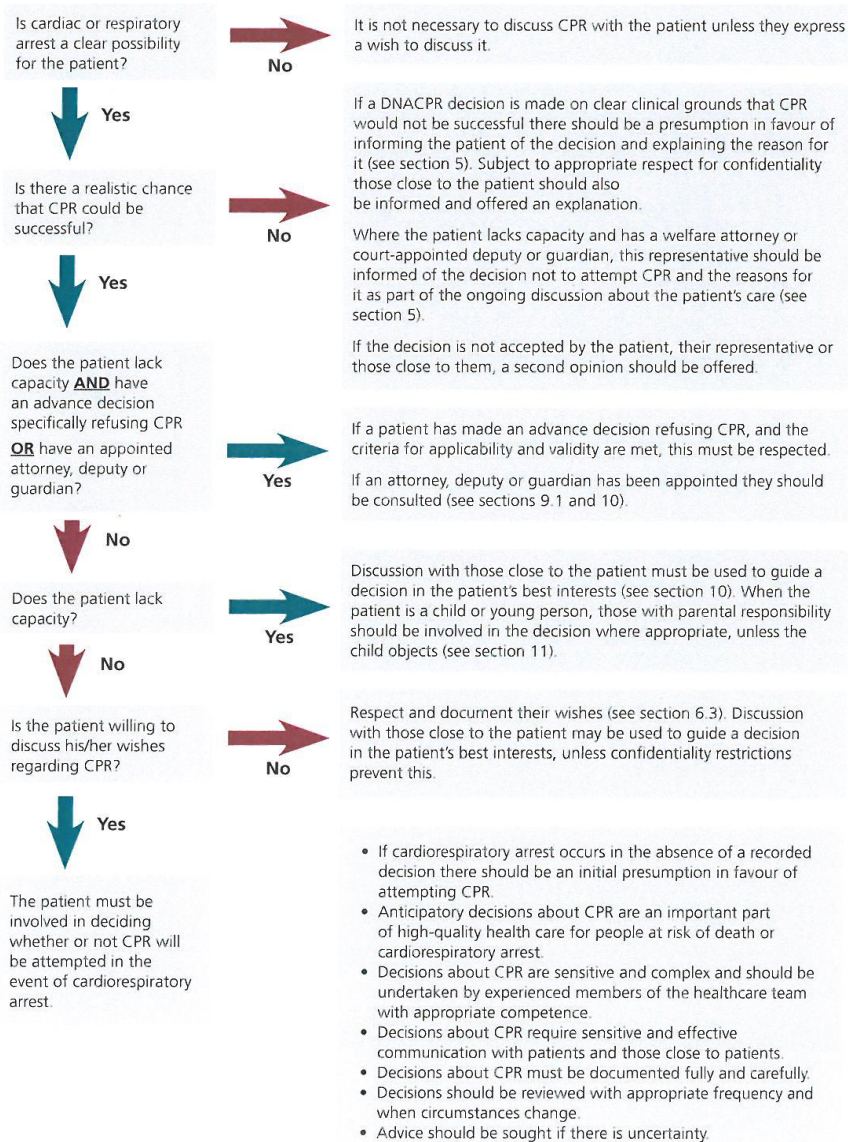
### **5.0 *Ambulance Transportation***

Where a patient with a DNACPR order is to be transferred via the Northern Ireland Ambulance Service (NIAS), this should be made clear to NIAS at the time of booking. Should the DNACPR status of the patient change prior to transportation, then NIAS must be informed of this change at the earliest convenience. A DNACPR Transport Form must be completed by medical and nursing staff to be given to the collecting representative from NIAS - **See Appendix 4.**

## 6.0 References

- Decisions Relating to Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007.
- Decisions Relating to Cardiopulmonary Resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 3<sup>rd</sup> edition, October 2014.
- Decisions Relating to Cardiopulmonary Resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 3<sup>rd</sup> edition, (1<sup>st</sup> revision) October 2015.
- Do Not Attempt Resuscitation (DNACPR) Policy, NHS Lothian, July 2007.
- Do Not Attempt Resuscitation (DNACPR) Policy, NHSCT July 2012.
- Guideline for End of Life Care: Critical Care Network Northern Ireland, January 2009.
- Human Rights Act 1998.
- Policy on Consent for Examination, Treatment or Care, SHSCT April 2009.
- Reference Guide to Consent for Examination, Treatment or Care: Department of Health, Social Services and Public Safety, March 2003.
- The Code – Standards of Conduct, Performance and Ethics for Nurses and Midwives: Nursing and Midwifery Council, April 2008.
- Withholding and Withdrawing Life-Prolonging Treatments: General Medical Council, August 2002.
- Treatment and Care Towards The End of Life: Good Practice in Decision-Making: General Medical Council, May 2010.

# Decision-making framework



**DO NOT ATTEMPT CARDIOPULMUNARY RESUSCITATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_

Hospital number \_\_\_\_\_



Date of DNACPR Order:

/ /

**DO NOT PHOTOCOPY**

**In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. 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 7 **Yes / No**

**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. If this decision has not been discussed with the patient state the reason why:

**4** Summary of communication with patient's relatives or next of kin:

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

**6** If a Medical Assisted device is in place has it been deactivated as per Trust protocol? **Yes / No**

**7** Healthcare professional completing this DNACPR order:

Name \_\_\_\_\_ Position \_\_\_\_\_

**8** Review and endorsement by most senior health professional:

Signature \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_

**DATE NEXT REVIEW DUE:**

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**DATE REVIEWED:**

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**STATUS / DECISION:**

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**SIGNATURE:**

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**GRADE:**

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**DATE NEXT REVIEW DUE:**

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**DATE REVIEWED:**

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**STATUS / DECISION:**

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**SIGNATURE:**

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**GRADE:**

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## All sections should be completed

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

1. **Capacity / advance decisions**

Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient's current circumstances.

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

Be as specific as possible.

3. **Summary of communication with patient .....**

State clearly what was discussed and agreed. If this decision was not discussed with the patient, state the reason why this was inappropriate. It is not essential to discuss CPR with every patient. If a patient is in the final stages of a terminal illness and discussion would cause distress without any likelihood of benefit, this situation should be recorded.

4. **Summary of communication with patient's relatives or friends**

If the patient does not have capacity, their relatives or friends must be consulted and may be able to help by indicating what the patient would decide, if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity, ensure that discussion with others does not breach confidentiality.

State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. **Members of multidisciplinary team .....**

State names and positions. Ensure that the DNAR order has been communicated to all relevant members of the healthcare team.

6. **Healthcare professional completing this DNAR order**

This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7. **Review / endorsement .....**

The decision must be endorsed by the most senior healthcare professional responsible for the patient's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.

# RESUSCITATION STATUS ADVISORY

## DO NOT ATTEMPT RESUSCITATION



For the attention of Northern Ireland Ambulance Service Crews



NIAS Booking Ref:

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**Patient Details**

<p><b>Patient first name:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>Patient surname:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>Date of Birth</b>  d d / m m / y y y y</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>GP Name/Address/Contact Detail:</b></p> <table border="1" style="width: 100%; height: 40px;"> <tr> <td style="width: 100%;"> </td> </tr> </table>																														<p><b>Destination Address:</b></p> <table border="1" style="width: 100%; height: 80px;"> <tr> <td style="width: 100%;"> </td> </tr> </table> <p><b>Patient Address:</b></p> <table border="1" style="width: 100%; height: 80px;"> <tr> <td style="width: 100%;"> </td> </tr> </table> <p><b>Post Code:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table>								

**Because of advanced disease status it is now not appropriate to perform CPR or Advanced Life Support on the above patient if they suffer a cardiac or respiratory arrest whilst being transported in your vehicle.**

The above patient has a non-reversible condition and it is the opinion of their multi-professional team that cardiopulmonary resuscitation measures would not be in their best interest. All other appropriate treatment and care must be provided.

If death should occur before arriving at your destination, please call hospital staff on the telephone number below to discuss management of the deceased. Do not automatically take the deceased to the nearest Emergency Department. This form must be attached to the relevant NIAS PRF for return to NIAS Audit Department.

<p><b>Authorising Clinician:</b></p> <p><input type="checkbox"/> Consultant   <input type="checkbox"/> Registrar   <input type="checkbox"/> GP</p> <p><b>Signed:</b></p> <table border="1" style="width: 100%; height: 30px;"> <tr> <td style="width: 100%;"> </td> </tr> </table> <p><b>First name:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>Surname:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>Position/Contact Detail:</b></p> <table border="1" style="width: 100%; height: 40px;"> <tr> <td style="width: 100%;"> </td> </tr> </table> <p><b>Date:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table>																													<p><b>Second Authorisation:</b></p> <p><input type="checkbox"/> Sister   <input type="checkbox"/> Charge Nurse   <input type="checkbox"/> Deputy</p> <p><b>Signed:</b></p> <table border="1" style="width: 100%; height: 30px;"> <tr> <td style="width: 100%;"> </td> </tr> </table> <p><b>First name:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>Surname:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>Position/Telephone/Extension:</b></p> <table border="1" style="width: 100%; height: 40px;"> <tr> <td style="width: 100%;"> </td> </tr> </table> <p><b>Date:</b></p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table>																												

**Supported by the following Northern Ireland Health & Social Care Trusts: Belfast, Northern, South Eastern, Southern, Western and Northern Ireland Ambulance Service**  
Developed by the Northern Ireland Resuscitation Organisation

Advise ambulance control of DNAR status at time of booking and insert NIAS booking reference number at the top of this page.  
Advise ambulance control immediately if there is any change in the patient's DNAR status

Form: DNARtransfer V8

