

**DOCUMENT CONTROL**

<b>Title:</b>	<b>Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Adult Policy</b>
<b>Version:</b>	<b>2</b>
<b>Reference Number:</b>	<b>CL039</b>
<b>Scope:</b>	
This policy applies to all the multi-professional health, social and tertiary care teams involved in a person's care aged eighteen years and over and across the range of settings within Pennine Care NHS Foundation Trust.	
<b>Purpose:</b>	
The purpose of this document is to describe a framework developed by North West Strategic Clinical Networks (SCN's) and the North West Ambulance Service (NWAS) in collaboration with key stakeholders to ensure that uDNACPR decisions: <ul style="list-style-type: none"><li>• Respect the wishes of the individual, where possible</li><li>• Reflect the best interests of the individual, and</li><li>• Provide benefits which are not outweighed by burden.</li></ul> This policy will provide clear guidance for health and social care staff and will ensure that uDNACPR decisions refer only to CPR and not to any other aspect of the individual's care or treatment options.	
<b>Requirement for Policy</b>	
The North West uDNACPR document has undergone full NHS England legal review as part of the development process.	
<b>Keywords:</b>	
Resuscitation, DNA, do not attempt, CPR, Cardiopulmonary Resuscitation, Lilac Form	
<b>Supersedes:</b>	
Version 1	
<b>Description of Amendment(s):</b>	
This version replaces version 1 in its entirety and replicates the North West Anticipatory Clinical Management Planning Guidance including Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR), developed by North West Strategic Clinical Networks (SCN's) and the North West Ambulance Service (NWAS) in collaboration with Greater Manchester and Eastern Cheshire Strategic Clinical Networks and North West Coast Strategic Clinical Networks. It differentiates between Advanced Care Planning for personal care preferences and introduces a new term, Anticipatory Clinical Management Plan for Healthcare Professions to future plan for clinical needs.	

<b>Owner:</b>	
The Medical Director – Henry Ticehurst	
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This document has been developed in collaboration with the following interested parties: <ul style="list-style-type: none"> <li>• Pennine Care Acute Medical Partner NHS Agencies</li> <li>• Pennine Care Foundation Trust Resuscitation Committee – August 2018</li> </ul>	
<b>Individual(s) &amp; group(s) involved in the Consultation:</b>	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: <ul style="list-style-type: none"> <li>• Acute Care Forum</li> <li>• Older Peoples Care Forum</li> <li>• Community Services Care Forum</li> </ul>	
<b>Equality Impact Analysis:</b>	
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<b>Review:</b>	
<b>Next review date:</b>	September 2021
<b>Responsibility of:</b>	Trust Resuscitation Officer

<b>Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):</b>	
CL009	The Resuscitation Policy
CO093	Protocol for the Management of Mental Health & Specialist Services Health Records
CO099	Protocol for the Management of Community Services Health Records
<b>Policy Associated Documents:</b>	
UDNACR NW  Lilac Form	These forms are supplied in a book, with the above title, with the reference code uDNACPRTRUST V2 09/14 for reordering purposes <a href="https://www.nwas.nhs.uk/media/807454/uDNACPR-NW-form-v1-2.pdf">https://www.nwas.nhs.uk/media/807454/uDNACPR-NW-form-v1-2.pdf</a>
ReSPECT	<a href="https://www.respectprocess.org.uk/pdfs/ReSPECT-Act-and-Adopt.pdf">https://www.respectprocess.org.uk/pdfs/ReSPECT-Act-and-Adopt.pdf</a>
uDNACPR Senior Nurse / GP Competency Framework	Nurse / GP Led Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) competency training package <a href="#">NHS North of England Nurse / GP Led uDNACPR Training Package</a>
<b>Other external documentation/resources to which this policy relates:</b>	
<a href="http://www.gmecscn.nhs.uk">www.gmecscn.nhs.uk</a>	Decision Making Framework (Adapted from Guidance from the British Medical Association, the Resuscitation Council (UK)
<a href="http://www.gmecscn.nhs.uk">www.gmecscn.nhs.uk</a>	Recommended Summary Plan for Emergency Care & Treatment (ReSPECT) document, poster; Accept & Adopt. <b><i>Please note Pennine Care will introduce this in conjunction with our partner hospital trusts, social and primary care agencies &amp; a full communication strategy for ReSPECT will be undertaken prior to launch</i></b>
<a href="http://www.gmecscn.nhs.uk">www.gmecscn.nhs.uk</a>	NoENW Nurse GP uDNACPR Competency Training Package
	Mental Health Act
	Mental Capacity and DoLS Assessment Guidance
	The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) Guidance 2016
<b>CQC Regulations</b>	
<b>This policy supports the following CQC regulations:</b>	
Regulation 9	Person centred care
Regulation 10	Dignity and respect
Regulation 11	Need for consent
Regulation 12	Safe care and treatment

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## 1. PURPOSE

Provide guidance around Anticipatory Clinical Management Planning discussions and decision making as well as communication and documenting these discussions

To acknowledge the centrality of people in decisions about the treatment that they receive and to support shared decision making between people and those providing care and treatment to them.

To support practitioners in decision making, assessing/reviewing and recording Information in relation to clinical anticipatory planning including Do Not Attempt cardiopulmonary Resuscitation (uDNACPR), as well as Advance Care Planning, across all health and social care settings

To make clear the legal requirements of Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) documentation

To support the use of uDNACPR documentation to **guide** immediate decision making in an emergency, and not to replace more detailed care plans or comprehensive documentation that includes details of discussions that have taken place. Such discussions must be documented in the relevant health and care record in line with professional record keeping policies

To support advance care planning for those who choose to participate in this process, whether or not they have an advanced, progressive illness

To support the right of people aged 18 years and above to refuse in advance, any treatment, even if that treatment is life sustaining. This right applies to adults with the mental capacity to refuse treatments in advance in line with current legislation

To support the legal requirement to treat those who lack mental capacity in relation to a particular decision, in their best interest. This extends to making decisions about potentially life sustaining treatments on behalf of a person, including decisions about Cardiopulmonary Resuscitation

To support the use, transfer and acceptance of Anticipatory Clinical Management Planning including uDNACPR documentation across organisational boundaries, accompanying the person and applying in all settings

To provide guidance that complements, rather than replaces or duplicates, existing relevant local healthcare policies and procedures.

This guidance purposefully **does not** provide a comprehensive guide to completing the variety of different documentation available to record uDNACPR decisions. Within the resuscitation training for immediate life support the completion of the documentation will be referenced

## 2. SCOPE

This guidance focuses on discussions and shared decision making regarding anticipatory clinical management plans rather than the paperwork it is recorded on. These discussions may include ceilings of care and uDNACPR.

The uDNACPR paperwork currently in use in Pennine Care are the uDNACPR lilac forms (please see Policy Associated Documents – uDNACR NW). This policy will be updated as the Trust and its partner organisations review the use of paperwork in the introduction of the new North West unified do not attempt CPR documentation.

ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)	
<p>Consider using this form (as part of Advance Care Planning (ACP)). If you would not be surprised if the patient were to die in the next year.</p> <p>This is NOT an Advance Decision to Refuse Treatment (ADRT). www.adrt.nhs.uk</p> <p><b>Explanation Notes</b> This form should be completed legibly in black ball point ink</p> <ul style="list-style-type: none"> <li>The person's full name, NHS or Hospital number, date of birth, date of writing the decision and institution name should be completed and written clearly. Address may change due to person's deterioration e.g. into a nursing home. If other information is correct the form remains valid even with incorrect address.</li> <li>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 staff. It is the responsibility of the healthcare staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4, on form).</li> <li>Electronic form must be printed and signed on lilac paper and copies kept for audit purposes and notes.</li> <li>Triplicate forms, keep together until person is discharged/dies or decision is cancelled. Lilac with the person, 1st white copy for audit and 2nd white copy remain in the notes.</li> </ul> <p><b>Compulsory sections of the form: Top section, Section 1 and Section 2</b></p>	
1. Reason for DNACPR decision	<p><b>1.A CPR is unlikely to be successful</b></p> <p>Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person's best interests. Be as specific as possible. Patients have a right, under Article 8 of the European Convention on Human Rights, to be consulted / informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. Record the details of discussion or the reason for not discussing in the person's notes.</p> <p><b>1.B CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the person</b></p> <p>Summary of communication with person. State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate. Patients have a right, under Article 8 of the European Convention on Human Rights, to be consulted / informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. If the person does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the person would decide if able to do so. If there is no one appropriate to consult and the person has been assessed as lacking capacity then an instruction to an Independent Mental Capacity Advocate (IMCA) should be considered. If the person has made a Lasting Power of Attorney (LPA), 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 person if this power is included in the original Lasting Power of Attorney. You need to check this by reading the LPA. If the person has capacity ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives / relevant others with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.</p> <p><b>1.C DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent</b></p> <p>Check for the validity and applicability of the Advance Decision to Refuse Treatment (ADRT). Is the ADRT – 1. Specific to CPR? 2. In writing, signed and witnessed? 3. Contains the statement "even if life is at risk". 4. Has the person been consistent with their ADRT? If the answer to all the above is "Yes" the ADRT is valid and applicable. If the ADRT contains specific circumstances when CPR would not be appropriate write these on the form. Attach a copy of the ADRT to the person's DNACPR form.</p>
2. Person making this DNACPR decision/ Verification	State names and positions. In general this should be the most senior healthcare professional immediately available. If the decision is made by a delegated professional it must be verified by the most senior healthcare professional responsible for the person's care at the earliest opportunity. If the person making the decision is the most senior person, verification is not required.
3. Review	All decisions should be regularly re-assessed at appropriate intervals, such as (if patient condition changes) regardless of whether a review date has been specified. This decision will be regarded as "ONGOING" unless: <ol style="list-style-type: none"> <li>a definite review date is specified</li> <li>there are changes in the person's condition</li> <li>their expressed wishes change</li> </ol> Reviewer needs to complete all details on the form and document the outcome in the notes.
4. Who has been informed of this DNACPR decision?	Please ensure that all health and social care staff who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the person. It is the responsibility of health and social care staff to ensure those who have been informed of the decision are informed if the patient dies, or the form is cancelled.
5. Other Important Information	This information needs to be very clear and precise. For example, if transferring include name, address and telephone number of destination and next of kin. Ceilings of treatment include where ACP is kept. Preferred place of care should be noted.
Tear off slip	Complete details and place in "message in a bottle" if available with location clearly stated. For example, "In the nursing notes in the top drawer of the bedside in the dining room."

LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR. WHITE FORMS FOR AUDIT AND NOTES. ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) In the event of cardiac or respiratory arrest no attempts at CPR will be made. All other appropriate treatment and care will be provided.	
Version 1.2 - Sept 2014	<p>Name: _____ Date of DNACPR Decision: _____ NHS</p> <p>Address: _____ Institution Name: _____</p> <p>Post code: _____ Form completed electronically? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date of birth: / / Consent: _____</p> <p>NHS or hospital number: □□□□□□□□□□ Has the patient consented to share this decision with other Health Care Professionals? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Before completing this form, please see explanation notes</b></p> <p><b>1. Reason for DNACPR decision: (select A, B or C) NB – DNACPR decisions should rarely be made without informing or consulting the patient or their family</b></p> <p><input type="checkbox"/> <b>A) CPR is unlikely to be successful due to</b></p> <p>This decision has been discussed with the person Yes <input type="checkbox"/> No <input type="checkbox"/> If no state reason The relevant other has been informed of the decision Yes <input type="checkbox"/> No <input type="checkbox"/> If no state reason Name of relevant other: _____</p> <p><input type="checkbox"/> <b>B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person.</b></p> <p>Person involved in discussions? Yes <input type="checkbox"/> No <input type="checkbox"/> If no state reason</p> <ul style="list-style-type: none"> <li>Person lacks mental capacity and has a legally appointed Welfare Attorney: Name _____ Relationship (s) _____</li> <li>Person lacks mental capacity and does not have a legally appointed Welfare Attorney. This decision is made in accordance with the person's best interest. This decision has been reached in consultation with those close to the patient including: Name(s) _____ Relationship (s) _____</li> </ul> <p><input type="checkbox"/> <b>C) There is a valid advance decision to refuse CPR in the following circumstances: All circumstances Yes <input type="checkbox"/> No <input type="checkbox"/></b></p> <p>Specific Circumstances (please state): _____</p> <p><b>2. Healthcare professional making this DNACPR decision:</b></p> <p>Name: _____ Position: _____ GMC/NMC: _____</p> <p>Signature: _____ Date: / / Time: _____</p> <p>If decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:</p> <p>Name: _____ Position: _____ GMC/NMC: _____</p> <p>Signature: _____ Date: / / Time: _____</p> <p><b>3. Review:</b> NB – All DNACPR decisions are subject to ongoing monitoring</p> <p>Review date if appropriate: / / Outcome of review: DNACPR to continue? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Name: _____ Position: _____ GMC/NMC: _____</p> <p>Signature: _____ Date: / / Time: _____</p> <p><b>4. Who has been informed of this DNACPR decision?</b></p> <p><input type="checkbox"/> GP <input type="checkbox"/> Ambulance Warning Flag <input type="checkbox"/> Out of Hours</p> <p><input type="checkbox"/> Care Provider (Please state) _____</p> <p><input type="checkbox"/> Other (Please state) _____</p> <p><b>5. Other important information:</b></p> <p>For example, ambulance crew instructions on transfer, Ceilings of treatment, Preferred place of care/death, Tissue or Organ donation.</p> <hr/> <p><b>The DNACPR form is located:</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>Post code: _____</p> <p>Date of birth: / /</p> <p>NHS or hospital number: □□□□□□□□□□</p> <p><b>Important: this form MUST be printed on lilac paper</b></p>

SEE TAD\_CL039\_Lilac Form

Recording of information should be in line with professional record keeping policies and documentation as stipulated by the Clinical Record Keeping Policy and Standards. Please refer to policies CO93 (if you work in mental health and/or specialist services) and CO99 (of you work in Community Services – non mental health).

This guidance applies for all the multi-professional health, social and tertiary care teams involved in a person's care aged eighteen years and over and across the range of settings within the North West

For children and young adults who may be in transition between services please refer to local guidance and policies

The Health Select Committee in 2015 recommended that the Government review the use of uDNACPR orders in acute care settings, including whether resuscitation decisions should be considered in the context of overall treatment plans. Therefore this guidance focuses on uDNACPR as part of a wider context of Anticipatory Clinical Management Planning.

### **3. RESPONSIBILITIES, ACCOUNTABILITIES, DUTIES**

This policy and its forms are relevant to all health & social care staff across all settings of care including primary, secondary, independent, ambulance and voluntary sectors who have adopted the guidance. It applies to all designations and roles. It applies to all people employed in a *Health and Social caring* capacity, including those employed by the local authority or employed privately by an agency.

**Decisions must always be made in accordance with existing legal requirements, with good clinical practice, and with local policy.**

A robust organisational governance framework is essential to ensure the most appropriate senior healthcare professional is the decision maker in relation to a uDNACPR decision in the context of an Anticipatory Clinical Management Plan



#### 4. GLOSSARY OF TERMS:

<p><b>Advance Care Planning (ACP)</b></p>	<p>A voluntary process through which people can make decisions, or engage in planning about the care that they may be offered at a time when they lack capacity to give or withhold consent. ACP may take the form of stating wishes, preferences and values in an 'advance statement', and may include (in England &amp; Wales) a legally binding refusal of a specific treatment (ADRT). As such, it is broader than, but includes, 'emergency treatment planning' (see below).</p> <p>Please refer to the Mental Capacity Act 2005, and local policy, for further information.</p>
<p><b>Advance Decision to Refuse Treatment (ADRT)</b></p>	<p><b><i>Advance Decision to Refuse Treatment (ADRT):</i></b> The MCA provides the framework for people aged 18 or over to make an ADRT and confirms the requirements that must be met to ensure that it is valid and applicable.</p> <p>An ADRT is a decision by an individual to refuse a particular treatment in specific circumstances in the future should they lose capacity to make the decision at that time.</p> <p>A valid and applicable ADRT is legally binding. In order for an ADRT relating to refusal of life-sustaining treatment, such as CPR, to be valid, it must: 1) be in writing; 2) be signed by the individual; 3) be witnessed and signed by the witness; and 4) include a statement that it is to apply even where the individual's life is at risk. The clinical team must also be satisfied that there is no evidence that the individual has withdrawn their decision since making it or done anything clearly inconsistent with its terms.</p>
<p><b>Advance Statement</b></p>	<p>An expression of a person's wishes, beliefs, values, or other information, made when a person has mental capacity to do so, that must be taken into account when decisions are being taken on behalf of a person who lacks mental capacity. Please refer to the Mental Capacity Act 2005, and local policy, for further information.</p>
<p><b>Best Interests</b></p>	<p>An objective measure of overall benefit to a particular person. Under the Mental Capacity Act 2005, decisions made on behalf of people who lack mental capacity to do so themselves, must be made in their 'best interests'.</p>

	<p>This process includes consideration of the wishes and values of the person, and consultation with those close to them (such as relatives and/or carers). Please refer to the Mental Capacity Act 2005, and local policy, for further information.</p>
<b>Cardiorespiratory arrest</b>	<p><b>Cardiorespiratory Arrest (CA)</b> is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal gasping respiration. In simple terms unless this can be reversed by CPR, it will inevitably lead to death.</p>
<b>Consent</b>	<p>The process by which a person, or person with parental responsibility, with the mental capacity to do so, accepts a treatment that is offered to them/their child. To be valid, consent must be given freely, and be based on adequate information. Please refer to GMC guidance on consent and local policy for further information.</p>
<b>Cardiopulmonary resuscitation (CPR)</b>	<p>An emergency procedure which may include chest compressions and ventilations, for a person in cardiorespiratory arrest, in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation Council (UK) guidelines.</p> <p>The chances of success vary, depending on several factors including the cause of the arrest and any underlying illness that the person may have. In English law, CPR is classed as a medical treatment.</p>
<b>A Court Appointed Deputy</b>	<p>Appointed by the Court of Protection, to make decisions in the Best Interests of those who lack capacity but they <b>cannot</b> make decisions relating to life-sustaining treatment.</p>
<b>Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) decision</b>	<p><b>Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR)</b> refers to a decision not to make efforts to restart breathing and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotics etc.</p> <p>A 'decision' that CPR should not be attempted for a particular person. Unless the person (age 18 years and above) has recorded this in a valid and applicable ADRT (in England &amp; Wales) this is not, strictly speaking, a 'decision', but a recommendation to guide clinicians present at the time of a future cardiorespiratory arrest.</p>

	It is those clinicians who must make the decision whether or not to attempt CPR. Such recommendations must be made in accordance with legal requirements, should follow good clinical practice, and should be documented clearly and correctly.
<b>Emergency treatment decisions</b>	The term often given to decisions about providing or limiting potentially life-sustaining treatments for a given person. Anticipatory decisions/recommendations about CPR are an example of emergency treatment planning. (See glossary entry for ' <i>emergency treatment plans</i> ', below.
<b>Emergency Treatment Plans – also known as Treatment Escalation Plans (TEPs)</b>	The term given to a written record of a shared decision-making process about care and treatment in a future emergency situation'. A ReSPECT document is an example of an emergency treatment plan.
<b>GP</b>	General practitioner. These are doctors in primary healthcare who are likely to have overall clinical responsibility for the care of a person outside of a hospital or hospice setting, and who are often the first point of contact for healthcare issues that are not immediately life-threatening.
<b>Health and Social Care Staff:</b>	Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.
<b>Healthcare professional with overall clinical responsibility (Sometimes referred to as the senior responsible clinician).</b>	The healthcare professional involved in a person's care who is ultimately professionally responsible for a person's health care in a given setting. This person will also be professionally responsible for engagement in the ReSPECT process and ensuring the quality of documentation for that person. For example, in a hospital, this will usually be the named consultant.
<b>Healthcare setting</b>	A place where a person receives health care from a distinct healthcare team, or a distinct healthcare professional with overall clinical responsibility. For example, a hospital, a person's home, a hospice and a nursing home are all different healthcare settings.
<b>Health records</b>	Often referred to as 'medical notes' or 'patient notes', a person may have separate health records in different places of care. For example, a health record may be the GP's records for a person at home, or the hospital's 'medical notes' when the person is in hospital. The increasing use of digital records that are interoperable can facilitate transfer of information between different sets of records.

<b>Independent Mental Capacity Advocate (IMCA):</b>	<p>An IMCA supports and represents the known wishes of a person who lacks capacity to make a specific decision at a specific time, and who has no family or friends who are appropriate to represent them. They must be consulted when a decision about either serious medical treatment or a long term move is being made.</p>
<b>Lasting Power of Attorney (LPA)</b>	<p><b><i>Lasting Power of Attorney (LPA):</i></b> The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to make a LPA by appointing a person with power of attorney for health and wellbeing who can make decisions regarding health and wellbeing on their behalf once capacity is lost.</p> <p>This applies only to individuals' age 18 years and above. A person given this power under the Mental Capacity Act 2005 has the power and responsibility to make certain decisions on behalf of a person who lacks capacity to do so. Only if an LPA gives decision-making power relating to 'health and welfare' can the attorney make decisions about a person's care and treatment. The attorney can make decisions about life-sustaining treatment such as CPR only if the LPA document states this specifically. In order to be valid, an LPA must have been registered with the Office of the Public Guardian.</p>
<b>Potentially life-sustaining treatment</b>	<p>Any medical treatment that, in the judgment of the healthcare professional with overall clinical responsibility for a person, has a significant chance of sustaining a person's life in a life-threatening situation. This may include CPR, clinically assisted hydration and nutrition, assisted ventilation and intravenous antibiotic therapy (this list is not exhaustive).</p>
<b>Mental Capacity</b>	<p>An individual aged 16 (between 16-18 years are treated under the Children and Young person's Advance Care Planning Policy) or over is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals will lack capacity if they are suffering from an impairment of, or disturbance in, the functioning of the mind or brain and are unable to demonstrate that they can do any of the following:</p> <ul style="list-style-type: none"> <li>• Understand information relevant to the decision provided to them in the most appropriate way for the individual; or</li> </ul>

	<ul style="list-style-type: none"> <li>• Retain that information for long enough to make a decision; or</li> <li>• Use or weigh that information as part of the process of making the decision; or</li> <li>• Communicate the decision, whether by talking or sign language or by any other means.</li> </ul>
<b>Mental Capacity Act 2005 (MCA)</b>	<p>The <b><i>Mental Capacity Act 2005 (MCA)</i></b> was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.</p> <p>The law in England &amp; Wales stipulates how those who lack mental capacity must be treated. It applies to people age 16 years and above. In England and Wales, children aged 16–17 years are presumed to have capacity to consent to treatment (Family Law Reform Act 1969s 8), but a refusal of treatment could potentially be overridden in their best interests. Legal advice should be sought.</p>
<b>Nominated deputy</b>	A healthcare professional with delegated clinical responsibility from the healthcare professional with overall clinical responsibility. The nominated deputy must have the knowledge and skills required. This may be, for example, a trainee doctor or a nurse.
<b>Provider organisation / healthcare provider organisation</b>	This is a broad term that refers to the organisations and institutions responsible for the provision of health care to a person in any setting. It includes, for example, hospitals, ambulance services, and General Practices.
<b>Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document</b>	The ReSPECT document summarises information and recommendations about emergency care and treatment for a person in the event of their clinical deterioration and them having a lack of capacity at the time. The document records recommendations about potentially life-sustaining treatments for a person, including a recommendation about CPR.
<b>Respiratory Arrest</b>	The cessation of normal respiration due to failure of the lungs to function effectively.

## 5. ANTICIPATORY CLINICAL MANAGEMENT PLANNING

This is a proactive clinical management plan prepared in advance for a clinical situation, predicted or thought likely to occur, to allow conversation and preparation for the future.

Please note that discussions and documentation are not solely aimed at decisions about limiting treatment but also to support people to articulate and share their views about treatments and approaches to care that they *do* want, as well as about those that they do not.

This guidance forms part of future care planning, but is not Advance Care Planning if it is not a personal plan made by the individual themselves i.e. it is an Anticipatory Clinical Management Plan. Advance Care Planning and Anticipatory Clinical Management Plans are both examples of future planning for individuals and should work in conjunction with end of life care planning for individuals identifying the person's preferences for and goals of care in the event of a future emergency.

The diagram below illustrates the personal and the health care professional's care planning status, made in the present or the future

	PRESENT	FUTURE
PERSONAL	Personal Needs	Advance Care Plan
CLINICAL	Clinical Care Plan	Anticipatory Clinical Management Plan

This guidance will be supportive to Advance Care Planning identifying the person's preferences for and goals of care in the event of a future emergency as well as being inclusive of Anticipatory Clinical Management Plan, which may include treatment escalation plans or ceilings of treatment discussions. The guidance will also ensure that uDNACPR decisions refer only to CPR.

This guidance will provide a framework to ensure that Anticipatory Clinical Management Plans including uDNACPR decisions:

- Respect the wishes of the individual, where possible
- Reflect the best interests of the individual
- Provide benefits which are not outweighed by burden.
- Record an agreed focus of care

## **6. uDNACPR DISCUSSIONS AND DECISIONS**

### **6.1 Cardiopulmonary Arrest and Cardiopulmonary Resuscitation**

For the majority of people receiving care in a hospital or community setting, the likelihood of cardiopulmonary arrest is small; therefore no discussion of such an event needs to occur routinely unless raised by the individual.

The chance of survival following Cardiopulmonary Resuscitation (CPR) in adults may be relatively low depending on the circumstances. Although CPR can be attempted for any person, there comes a time for some people, when it is not appropriate to do this. It may then be appropriate to consider making a Do Not Attempt Cardio Pulmonary Resuscitation (uDNACPR) decision to enable the person to live and die naturally and with dignity.

### **6.2 Unexpected Cardiac Arrest**

In the event of an unexpected cardiac arrest, CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless:

A valid uDNACPR decision or an Advance Decision to Refuse Treatment (ADRT), refusing cardio pulmonary resuscitation, is in place and made known. (NB – where there is recorded evidence that an individual has clearly expressed that he/she would not wish to receive CPR but has not made a formal ADRT which meets the requirements under the MCA, it is nonetheless important to consider the individual's wishes. In such circumstances, it is unlikely that it would be appropriate to perform CPR. However, if there is any doubt as to whether the individual's views remain the same, the balance lies in favour of preserving life)

A person with a registered Lasting Power of Attorney for health and welfare who has the authority to make the decision on behalf of the individual is present at the point of the arrest. This individual will then make the decision regarding acceptance or refusal of CPR. You will need to see the document to ensure it is registered and includes decisions about life sustaining treatment.

- It is concluded, having considered all necessary factors under the Best Interests' checklist that it is not in the individual's best interests.

### **6.3 Clinical Decision Making at the time of a Cardiopulmonary Arrest – No signs of life or prolonged signs of death**

In the event of registered health care staff finding a person with no signs of life and/ or clear clinical signs of prolonged death, and with no uDNACPR decision or an ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR (Some organisations may define other health care staff within this section).

Consideration of the following will help to form a decision, based on their professional judgement which can be justified and later documented:

- What is the likely expected outcome of undertaking CPR?
- Is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading?
- Is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interests decision on behalf of the individual.

The clinical responsibility for making emergency treatment decisions, including those in relation to CPR, rests with the most senior healthcare professional attending the person at the time that a decision must be made. This may be for example a GP, medical or nurse consultant, other doctor, nurse or paramedic, with appropriate skill to make these decisions. Decisions must always be made in accordance with existing legal requirements, with good clinical practice, with individuals' known wishes and with local policy.

Provided the registered health care staff has demonstrated a rationale for their decision-making which follows local and national guidance; the employing organisation will support the member of staff if this decision is challenged.

### **6.4 uDNACPR Decision Making**

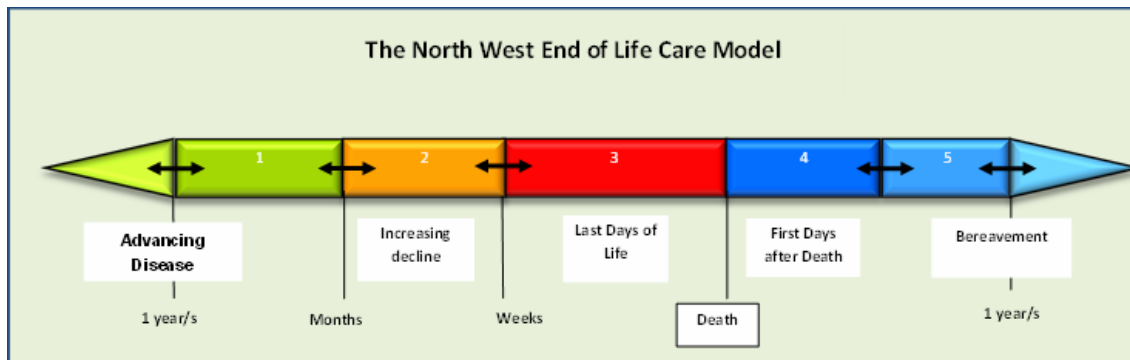
This Guidance is intended to be read in conjunction with The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) Guidance 2016.

Anticipatory Clinical Management Plan discussions, including that CPR should not be attempted for a particular person, form a recommendation to guide clinicians present at the time of a future cardiorespiratory arrest. It is those clinicians, at time of any cardiopulmonary arrest, who must make the clinical decision whether or not to attempt CPR.

When considering making a uDNACPR decision for an individual it is important to consider whether cardiac arrest is a clear possibility for this individual? If this is not a likely expected clinical circumstance, it may not be necessary to discuss further, and professionals should be aware of the resuscitation status for individuals under their care. In individuals where cardiac arrest might be expected to occur and where it is expected that there is a reasonable chance of success of CPR then the individual should be asked whether they would want it to be performed. The individual may ask for family or friends to be involved in the decision.



## Individuals in Last Days and Hours of life



(For full North West Model visit; <http://bit.ly/2zQiWYU>)

There will be some individuals for whom attempting CPR is inappropriate; for example, a person who is in the last days of life. In these circumstances CPR would not restart the heart and breathing of the individual, and should therefore not be attempted. Although CPR is a treatment for some situations does not mean it is an appropriate treatment for all situations. The individual and/or relatives/carers should be informed of this.

### 7. uDNACPR DECISION MAKING CIRCUMSTANCES

The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) Guidance 2016 "Decisions relating to cardiopulmonary resuscitation" states that CPR decisions may be made with and/or for:

Case:

1. a person who is at an advanced stage of dying from an irreversible condition, so CPR is contraindicated;
2. a person who has advanced illness and deteriorating health such that CPR will not work;
3. a person for whom CPR is a treatment option with a poor or uncertain outcome;
4. a person for whom CPR is quite likely to restore them to a quality of life that they would value.

In cases one and two, CPR will not be successful and should not be offered or attempted. This should be explained to the individual and/or those close to them (such as relatives and carers) unless to do so would cause them harm. This is information sharing as there is no decision for the individual to make in these circumstances.

In the cases three and four, the wishes of the individual are paramount. This involves consultation with the individual and shared decision making.

Such recommendations must be made in accordance with legal requirements, should follow good clinical practice, and should be documented clearly and correctly.

The decision-making framework is illustrated in Diagram 1 (See Trust Approved Documents – UDNACR NW). All uDNACPR decisions must be based on current legislation and guidance.

## **7.1 Resuscitation Discussions with individuals and those close to them – Consulting with individuals**

To comply with Article 8 of the European Convention on Human Rights, health professionals should explain uDNACPR decisions, and in cases three and four above individuals should be consulted – the presumption lies in favour of individual involvement in these decisions.

If a potential decision about CPR is deemed appropriate, then this should be discussed with individual and/or those close to them (such as relatives or carers) and this must be documented in the individual's notes. The individual's views and wishes in this situation are essential and must be taken in to account. However, no clinician is compelled to undertake an intervention that they feel is not an appropriate treatment of the clinical situation.

Where the uDNACPR decision has been made on the grounds that CPR will not work the individual should be **informed** of the uDNACPR decision unless the clinician considers that to do so is likely to cause the person to suffer physical or psychological harm or they have indicated a clear desire to avoid this discussion. In both cases, the clear and comprehensive reasons for excluding the individual from the discussion should be fully documented, as well as recording the decision about uDNACPR. It is important to note that the fact such a conversation may be distressing for the individual is not sufficient to justify their exclusion from the process.

If the uDNACPR decision has been made and there has been no discussion with the individual then, if they have capacity to make the decision, you should seek their agreement to share relevant information with those close to them (such as relatives and/or carers) so that they may support the individual's treatment or care.

A uDNACPR information leaflet should be made available where appropriate to individuals and their relatives or carers. It is the responsibility of each organisation to ensure that this is available and in different formats and languages.

If the individual wishes for this information to remain confidential, this should be respected and recorded within their notes.

It is only in very rare circumstances that a uDNACPR decision should be placed in an individual's notes without the person and/ or their family being informed. The reasons for doing so should be fully documented.

## **7.2 Advance Decision to Refuse Treatment (ADRT)**

An individual with mental capacity can make an advance decision to refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an ADRT. The decision is only legally binding if it is in writing, is signed, witnessed and includes a statement that it is to apply even if the individual's life is at risk. . It is good practice to have a uDNACPR form with the ADRT but it is not essential.

A verbal refusal should be documented by the professional to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented.

### **7.3 Individuals insisting that they would wish for treatments including CPR – Disagreement with individuals/ families**

Individuals may try to insist on treatments including CPR being undertaken even if the clinical evidence suggests that it will not be successful. In such circumstances, a comprehensive discussion with the individual should be held in order to better understand the reasons for their views. This discussion should be supported by relevant written patient information. A second opinion may assist in helping the individual or those close to them (such as relatives and/or carers) to understand the decision.

Individuals do not have a right to demand that doctors carry out treatment, including CPR, against their clinical judgement. However, generally, where an individual requests a treatment including, CPR, to be attempted then their wishes should be considered, except in cases where the clinicians are clear that these treatments such as CPR would not be successful.

If the individual does not accept the decision a second opinion should be offered, whenever possible. Similarly, if those close to the individual (such as relatives and/or carers) do not accept a uDNACPR decision in these circumstances, despite careful explanation, a second opinion should be offered. The courts have confirmed that there is no legal obligation to offer to arrange a second opinion in cases where the individual is being advised and treated by a multidisciplinary team all of whom take the view that a uDNACPR decision is appropriate.

If no consensus can be reached with the individual and those close to them (such as relatives and/or carers), consider whether legal advice should be sought before decision making, including uDNACPR, is implemented.

### **7.4 Individual who lacks capacity re: Anticipatory Clinical Management Plans including uDNACPR decision making**

If the individual lacks capacity, check whether they have made a valid and applicable Advanced Decision to Refuse Treatment (ADRT) that refuses the treatment in question (including CPR) or have appointed a person with power of attorney for health and welfare with appropriate authority. If so, follow this decision or consult with the Lasting Power of Attorney (LPA) accordingly, having reviewed the relevant ADRT or LPA paperwork.

For Anticipatory Clinical Management Plans, there needs to be a discussion with the LPA as though they were the individual. In cases one and two re: uDNACPR decision making it is necessary to inform the LPA of the decision, whilst in cases three and four the LPA should be consulted as though they were the individual themselves.

Where there is no LPA and where **the individual lacks capacity**, under the Mental Capacity Act (MCA), to make decisions regarding Anticipatory Clinical Management Plans, including uDNACPR; inform those close to the individual (such as relatives and/or carers) in cases one and two. In cases three and four there is a duty to make the decision in the individual's best interests and to consult with those close to the individual (such as relatives and/or carers) unless there is a good reason not to i.e. there is a risk of physical or psychological harm or it is not practicable to do so. The discussion with those close to the individual should focus on what the individual's wishes would be if they had capacity.

Individuals, family or friends have a right to decline to take part in the discussions. Where there is no-one to consult with then consideration should be given to instructing an Independent Mental Capacity Advocate (IMCA).

### **7.5 Situation where Independent Mental Capacity Advocate (IMCA) is required**

Where an individual who lacks capacity has no one close to them with whom health professionals can consult (i.e. is unbefriended) and decisions are being made about serious medical treatment (such as the implementation of a uDNACPR order in cases three and four), a referral should be considered to the local Independent Mental Capacity Advocacy service for an IMCA to be appointed for the individual. In such cases, the role of the IMCA is to check that the Best Interests principle has been followed ensure that the individual's wishes and feelings have been appropriately considered and to request a second opinion if necessary. There is no requirement to instruct an IMCA for a uDNACPR decision in cases one and two, as there is no consultation and decision making required. In those cases seeking a second opinion should be considered in any event.

The input of an IMCA may not be available immediately and, if urgent decisions are required to be made before the involvement of an IMCA can be arranged then they may be made in accordance with the individual's best interests; the referral process should not prevent appropriate care planning taking place whilst the input of an IMCA is awaited. However, any decisions made prior to the IMCA's involvement should be reviewed following receipt of the IMCA's report. Information provided by the IMCA must be taken into account when considering an individual's best interests.

In case of uncertainty, there should be a strong but not absolute, presumption in favour of providing treatment that is potentially life sustaining.

Please note if there is clear evidence of a recent verbal refusal of CPR whilst the person had capacity then this should be carefully considered when making a best interests decision.

## **8. REVIEW OF DISCUSSIONS AND DECISIONS**

Anticipatory Clinical Management Plans including uDNACPR decisions should be subject to ongoing monitoring to ensure they remain appropriate - it is recommended that professionals identify timings to review these decisions. All reviews should be documented in the individual's records. Decisions should be regarded as ongoing, with further clinical reviews if required, requested by the individual or their family/carers or a routine planned clinical review of the decision is undertaken.

Reassessing the decision regularly does not mean burdening the individual and their family with repeated decision-making discussions, but it does require staff to be sensitive in picking up any change of views during discussions with the individual or their family. Where an individual has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

It is important to note that the individual's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, each time that a treatment decision including uDNACPR is reviewed, the reviewer must consider whether the

person can contribute to the decision-making process.

Anticipatory Clinical Management Plans including uDNACPR should always be reviewed if:-

- There is a change of clinical circumstances
- Change of setting

## **9. DOCUMENTATION OF ANTICIPATORY CLINICAL MANAGEMENT PLANNING INCLUDING uDNACPR DECISIONS**

### **9.1 Legal Status of documentation related to Anticipatory Clinical Management Plans including uDNACPR**

This is a clinical record of discussions and conversations that have taken place in anticipation of future clinical circumstances to facilitate future care planning.

At the time of the clinical situation occurring, the documentation should be taken in to account as a recommendation and as part of the decision making but has no further legal status regarding the decision itself at that time, unless it is in place as the individual has made an ADRT relating to CPR.

However, Clinicians should have, and be prepared to justify reasons to override this decision. If a valid ADRT is in place then this must be complied with.

### **9.2 Documenting Discussions**

At time of writing there are a number of documents in use to record Anticipatory Clinical Management Plans including uDNACPR decisions across the North West. These include:

- North West Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) (lilac form)
- Deciding Right documentation
- ReSPECT - records the persons expressed preferences for their future care and treatment; it constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'Advance Decision to Refuse Treatment (ADRT)
- Allow a Natural Death form
- Electronic Palliative Care Co-ordination Systems (EPaCCS)
- Local Trust documentation.

Once the decision has been made, it must be recorded on the appropriate organisation's clinical documentation, including any specific locality paperwork regarding Anticipatory Clinical Management Plans including uDNACPR.

Documentation in black and white is acceptable as long as this is identified as the latest copy.

Any paper documentation should stay with the person at all times including in an in-patient environment (e.g. hospitals or specialist palliative care in-patient units):

- The individual's full name, NHS or hospital number, date of birth, date of writing decision, review date if applicable and institution name should be completed and written clearly. Address may change due to person's deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address.

In certain localities there are Electronic Palliative Care Co-ordination Systems where this information can be included, or schemes in place to easily identify where paper documentation can be found. This is to aid location at the time of need, to read and review the decision and validity. One such scheme is 'message in a bottle' which is traditionally kept in a person's refrigerator. It is recommended that it is stated in persons' medical/ nursing notes/ clinical record or other documentation where the Anticipatory Clinical Management Plan or uDNACPR documentation can be located for ease of access for the ambulance service.

***Please note:***

- Information regarding the background to the decision, the reasons for the decision, those involved in the decision and a full explanation of the process, must be recorded in the individual's notes, additionally these can be recorded in care records, care plans etc.

**uDNACPR Documentation does not constitute a legally binding consent to or refusal of care or treatment (but be aware that the documentation may have been completed in conjunction with an existing ADRT which is legally binding). It should be used as a guide to best-interests decision-making by healthcare professionals in an emergency setting, in relation to emergency care, including potentially life-sustaining treatments.**

Anticipatory Clinical Management Plans including uDNACPR will remain active as an up-to-date plan for emergency care and potentially life-sustaining treatment until it is cancelled, the individual dies, or unless the decision-maker at the time has reasonable doubt that the document is not active, or not applicable to the current situation. The decision-maker should bear in mind that they should have good reason for and be prepared to justify a decision to go against an existing document that is active and applicable.

It is the health care staff's responsibility to ensure communication of the form to other relevant organisations. The use of an EPaCCS system is recommended to ensure communication of the decision across settings. It is recommended where the person is at home, the ambulance service is informed, using their warning flag procedure following local procedures.

### **9.3 Suspension of uDNACPR decision**

Uncommonly, some individuals for whom a uDNACPR decision has been established may develop Cardiac Arrest from a readily reversible cause. In such situations CPR would be appropriate, while the reversible cause is treated, unless the individual has specifically refused intervention in these circumstances.

Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation, such as anaphylaxis or choking. CPR would be appropriate while the reversible cause is treated.

Pre-planned: Some procedures could precipitate a Cardiac Arrest, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances, the uDNACPR decision should be reviewed prior to procedure and a decision made as to whether the uDNACPR decision should be suspended. Discussion with key people, including the person if appropriate, will need to take place.

#### 9.4 Cancellation of uDNACPR Decision

In rare circumstances, a decision may be made to cancel or revoke the uDNACPR decision. If the decision is cancelled, the document should be crossed through with two diagonal lines in black ball-point ink and the word '**CANCELLED**' written clearly between them, dated, signed and name printed by the health care staff. The cancelled document is to be retained in the person's notes. **It is the responsibility of the health care staff cancelling the uDNACPR decision to communicate this to all parties informed of the original decision.**

Organisations should provide a mechanism for electronic versions of the uDNACPR decision to be able to be cancelled electronically within their systems.

On cancellation or death of the person at home, the health and social care staff dealing with the person, **MUST** inform the ambulance service that cancellation or death has occurred.

#### 9.5 Mental Capacity Act and Legal Considerations

This guidance must only be used by individuals who are trained and competent in the application of the Mental Capacity Act (2005) (MCA) and in full accordance with organisational MCA policy and related guidance or procedures.

This guidance should be read and applied in conjunction with the MCA.

This guidance will provide clarity for health and social care staff that uDNACPR documentation does not constitute a legally binding refusal of treatment, but be aware that the documentation may have been completed in conjunction with an existing ADRT which is legally binding. It should be used as a guide to best interest decision making by health and social care professionals in an emergency situation, in relation to potentially life sustaining care and treatments.

**Confidentiality:** If the individual has the mental capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity, and their views on involving family and friends are not known health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individual's care and is not contrary to their interests.

The following provisions of the Human Rights Act 1998 are relevant to this guidance:

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14).

## 10. GOVERNANCE

Anticipatory Clinical Management Planning including uDNACPR decision-making process is implemented monitored and reviewed to ensure a robust governance framework. *For example see Front Cover Sheet – Trust Approved Documents - ReSPECT.*

Please note Pennine Care NHS Foundation Trust is working to implement this guidance and services will receive communication as to the progress of implementation as defined in ReSPECT and the rest of section 8.

This guidance has been reviewed by NHS England (North) legal advisers to ensure it provides a robust framework underpinned by relevant national guidance and legislation. Organisations adopting this guidance should also ensure it is reviewed by their local legal services.

An Equality Impact Assessment (EIA) in line with organizational guidance has been undertaken .

Commissioners and provider organisations should ensure:

- That commissioned services are aware of and adhere to the guidance and procedure as per local contracts
- That pharmacists, dentists and others in similar health and social care occupations are aware of this guidance
- That education and training is available and provided in line with the guidance.
- This should be the subject of regular audit
- Audit of provider organisations' compliance with agreed uDNACPR documentation, record of decision making, and any complaints/ clinical incidents involving the guidance.

## 11. AUDIT AND MONITORING

Individual organisations should assure, monitor and evaluate compliance with this guidance through audit and data collection using Key Performance Indicators. Whilst it is acknowledged auditing this area of work can be challenging it is essential for developing practice and maintaining individual and professional safety.

The Trust Resuscitation Committee and End of Life Groups will have have clear governance arrangements in place which indicate individuals and actions, who are responsible for this guidance and audit. This may include:

- Data collection
- Review of completion of documentation via retrospective audit
- Decision making and process via prospective audit
- As part of wider Mortality review local Trust processes
- Developing and ensuring that action plans are completed and sharing good practice
- Monitoring of incident reports and complaints regarding Anticipatory Clinical Management Planning including the uDNACPR process.



Local leads will decide the number of Anticipatory Clinical Management Plans including uDNACPR documentation to be reviewed and to agree the audit process locally.

Anticipatory Clinical Management Plans/ uDNACPR documentation will be retained and stored for the purpose of retrospective audit so that it is easily accessible for retrospective audit.

Audit and Monitoring information should be used for future planning, identification of training needs and for guidance review.

Whilst local audit is essential this revised guidance recommends compliance with national available audits to improve practice e.g. the National hospital audit and VOICES questionnaire. This will be reviewed and decided up by the Trust Resuscitation Committee

## 12. WHO CAN MAKE THE DECISION?

The clinical responsibility for making emergency treatment decisions, including those in relation to CPR, rests with the most senior healthcare professional attending the person at the time that a decision must be made, or a nominated deputy.

The decision to agree an Anticipatory Clinical Management Plan and or a uDNACPR decision should therefore be made by:

- Consultant/ General Practitioner
- Doctor who has been delegated the responsibility by their employer
- Registered nurse who has achieved the required competency - The Nursing and Midwifery Council state that the Code requires all nurses to practice with best available evidence, safely and effectively at all times in line with the requirements of The Code (2015) and the current legal position is that nurses may verify death but they cannot certify death.
- Other Professional with the required competency and is willing to lead these discussions. See Front Control Sheet – Trust Approved Documents - uDNACPR Senior Nurse / GP Competency Framework for examples of competency frameworks

**Organisations** must ensure that Anticipatory Clinical Management Planning including any uDNACPR decision is verified by a professional with overall responsibility at the earliest opportunity.

**Professionals** leading, discussing and making Anticipatory Clinical Management Plans including uDNACPR decisions must:

- Involve the individual where possible, following best practice guidelines when making a decision, and, if appropriate, involve relevant others in the discussion
- Be competent to make the decision
- Ensure that the senior clinician with overall responsibility reviews the decision made by the delegated professional at the earliest opportunity and in line with local guidance.

- Ensure the decision is documented
- Communicate the decision to other health and social care providers
- Review the decision if necessary.

**Health & social care staff delivering care must:**

- Adhere to the guidance and procedure
- Notify their line manager of any training needs
- Sensitively enquire as to any previous Anticipatory Clinical Management Planning/ uDNACPR discussions or decisions as well as the existence of any documentation including ACP or an ADRT
- Encourage the individual or their representative, where able, to inform those looking after them that there is a valid documented uDNACPR decision about themselves and where this can be found
- Check the validity of any decision
- Notify other services of the existence of the above on the transfer of a person
- Participate in the audit process.

**Ambulance staff** must ensure they adhere to the guidance including relevant organisational policies, procedures and guidance.

**The Chief Executive** of each organisation is responsible for:

- Ensuring that this guidance adheres to statutory requirements and professional guidance
- Supporting unified guidance development and the implementation in other organisations
- Ensuring that the guidance is monitored
- Reviewing the guidance, form and supporting documentation every two years
- Compliance, both clinical and legal with the regional guidance and procedure
- Ensuring the guidance is agreed and monitored by the organisation's governance process

**Directors or Managers** responsible for the delivery of care must ensure that:

- The guidance is implemented
- Staff are aware of the guidance and how to access it
- Staff understand the importance of issues regarding uDNACPR
- Staff are trained and updated in managing uDNACPR decisions
- Staff have undergone training in relation to the Mental Capacity Act and are competent to deliver care in line with current legislation the guidance is audited and the audit details are fed back to a nominated Director
- uDNACPR forms, leaflets and guidance are available as required.

### **13. EDUCATION AND TRAINING**

Training at a local/regional level will be available to enable staff to meet the requirements of this guidance.

Localities should develop a robust local training plan that reflects the needs and roles of different groups. Consider diverse approaches to education and content being comprehensive enough to be cover or signpost to supporting MCA, shared decision making and communication skills training. Take advantage of the knowledge of what works well and who has an interest in this area across the organisation

The delivery of education needs to be across the multi-professional team and should include all disciplines and organisations involved in the care of people at end of life or working in areas where emergency situation have a potential to occur.

### **14. LEGISLATION**

Health and social care staff are expected to understand how the MCA works in practice and the implications for each individual for whom a uDNACPR decision has been made.

Decision making professionals should complete the recognised competency training designed by each organisation and be indemnified by their organisation. *(For competency framework examples see Front Control Sheet – Trust Approved Documents - uDNACPR Senior Nurse / GP Competency Framework for examples of competency frameworks)*

### **15. DISCHARGE/TRANSFER PROCESS**

Effective communication concerning the individual's Anticipatory Clinical Management Plans, including resuscitation status, will occur among all members of the multi-professional healthcare team involved in their care and across the range of care settings. This should include carers and relatives where appropriate.

On discharge or people in their own home (from the care setting instigating locality documentation):

- The original documentation should stay with the person
- One copy remains in the clinical notes (e.g. hospital or primary care record)
- When transferring the person between settings all staff involved in the transfer of care of a person need to ensure that:
  - The receiving institution is informed of Anticipatory Clinical Management Plans including uDNACPR decision and provided with the individual's relevant documentation on arrival
  - Where appropriate, the person (or those important to the person if they lack capacity) has been informed of Anticipatory Clinical Management Plans including uDNACPR decision

- The decisions are communicated to all members of the health and social care teams involved in the person's ongoing care
- The ambulance service has been informed via the warning flag procedure.

If such discussion is likely to cause the individual harm then it is usually impossible to place a uDNACPR form in the person's home.

**Ambulance transfer:** If discussion has taken place regarding deterioration during transfer the relevant local clinical documentation must be completed by any health care staff, stating; the preferred destination (this cannot be a public place), the name and telephone number of next of kin or named contact person. If there are no details and the individual is being transferred, should they deteriorate, they will be taken to the nearest Emergency Department.

**Non ambulance transfer:** other organisations transferring individuals between departments, other healthcare settings and home should be informed of, and abide by, the uDNACPR decision, subject to any change in circumstances.

Current discharge letters should include information regarding Anticipatory Clinical Management Plans including uDNACPR decisions. It is important that it is noted that a review of these plans is required through the written communication.

**Crossing Boundaries:** If an individual moves settings or localities and there are different Anticipatory Clinical Management Plans including uDNACPR documentation in use, providing their documentation includes all the required information as outlined above, it will be recognised by health and social care staff, until a time that this decision and discussion is reviewed for application in care setting.

## 16. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

## 17. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

## 18. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

## 19. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

## 20. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

## 21. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

## 22. REFERENCES

“Respect” London Policy Version 16 October 2016 London Strategic Clinical Networks

ReSPECT website: <https://www.respectprocess.org.uk/>

Decisions related to cardiopulmonary resuscitation. Guidance from British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. 3<sup>rd</sup>. Edition (1st Revision) 2016

National guidance on CPR decisions published by the British Medical Association, the Resuscitation Council (UK) and the Royal College of nursing:

General Medical Council Withholding and Withdrawing guidance (2010)

House of Commons Health Committee **End of Life Care: Fifth Report of Session 2014–15** Printed 10 March 2015

Tracey Judgment: <https://goo.gl/yb4ALK>