Advanced Care Planning Documents Summary:

Advanced care planning documents summary:

Name of Document:

Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR)

Area document is in use

Nationally, although may vary slightly in appearance depending on locality.

Summary of document

This document informs all professionals involved in an individual's care that Cardiopulmonary Resuscitation (CPR) is not appropriate in the event of a natural death.

DNACPRs should be written in a personalised way – blanket policies indicating all individuals with a learning disability or dementia should have a DNACPR are not appropriate or lawful.

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNACPRadult.1(2015)

Name ______
Address ______
Date of birth ______
NHS number ______

Date of DNACPR decision: / /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. 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 6 YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. YES / NO

All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

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 (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:**

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

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

6 **Healthcare professional recording this DNACPR decision:**
Name ______ Position ______
Signature ______ Date ______ Time ______

7 **Review and endorsement by most senior health professional:**
Signature ______ Name ______ Date ______
Review date (if appropriate):
Signature ______ Name ______ Date ______
Signature ______ Name ______ Date ______

Roles and responsibilities

All care staff should know where to find an individual's DNACPR quickly in an emergency situation.

Managers of care providers should be able to advocate for the individuals accessing their service if a DNACPR has been filled out inappropriately or without necessary information.

Advanced care planning documents summary:

Name of Document:

Treatment Escalation Plan (TEP)

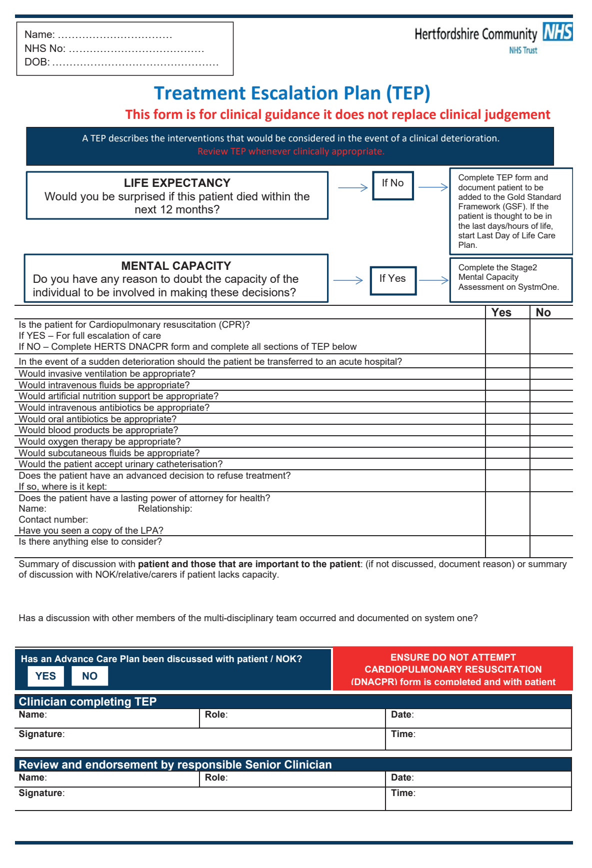
Area document is in use

All Hertfordshire localities.

Summary of document

This document includes what medical treatments may or may not be appropriate for an individual if they become unwell and cannot tell us their preferences. These can include treatments such as being placed on life support machines, medications being given directly into a vein, or medications being given orally.

The ReSPECT document includes a summary of TEPs in their wording.



Name: ....
NHS No: ....
DOB: ....

Hertfordshire Community NHS
NHS Trust

Treatment Escalation Plan (TEP)

This form is for clinical guidance it does not replace clinical judgement

A TEP describes the interventions that would be considered in the event of a clinical deterioration.
Review TEP whenever clinically appropriate.

LIFE EXPECTANCY
Would you be surprised if this patient died within the next 12 months? → If No → Complete TEP form and document patient to be added to the Gold Standard Framework (GSF). If the patient is thought to be in the last days/hours of life, start Last Day of Life Care Plan.

MENTAL CAPACITY
Do you have any reason to doubt the capacity of the individual to be involved in making these decisions? → If Yes → Complete the Stage2 Mental Capacity Assessment on SystmOne.

	Yes	No
Is the patient for Cardiopulmonary resuscitation (CPR)? If YES – For full escalation of care If NO – Complete HERTS DNACPR form and complete all sections of TEP below		
In the event of a sudden deterioration should the patient be transferred to an acute hospital?		
Would invasive ventilation be appropriate?		
Would intravenous fluids be appropriate?		
Would artificial nutrition support be appropriate?		
Would intravenous antibiotics be appropriate?		
Would oral antibiotics be appropriate?		
Would blood products be appropriate?		
Would oxygen therapy be appropriate?		
Would subcutaneous fluids be appropriate?		
Would the patient accept urinary catheterisation?		
Does the patient have an advanced decision to refuse treatment? If so, where is it kept:		
Does the patient have a lasting power of attorney for health? Name: Relationship: Contact number: Have you seen a copy of the LPA?		
Is there anything else to consider?		

Summary of discussion with **patient and those that are important to the patient**: (if not discussed, document reason) or summary of discussion with NOK/relative/carers if patient lacks capacity.

Has a discussion with other members of the multi-disciplinary team occurred and documented on system one?

Has an Advance Care Plan been discussed with patient / NOK? YES NO

ENSURE DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) form is completed and with patient

Clinician completing TEP		
Name:	**Role**:	**Date**:
Signature:		**Time**:

Review and endorsement by responsible Senior Clinician		
Name:	**Role**:	**Date**:
Signature:		**Time**:

Roles and responsibilities

All care staff and managers should know where to find an individual's TEP in an emergency situation.

Managers should ensure TEPs are stored in a location that is easily accessible in an emergency.

Advanced care planning documents summary:

Name of Document:

Advanced Decision to Refuse Treatment (ADRT)

NB these were previously called Living Wills – Living Wills written before 2017 are still legally binding.

Area document is in use

Nationally, however will vary widely in appearance as there is no set criteria for how an ADRT should look. An ADRT must be written and countersigned by a witness. The witness does not need to be a professional person e.g. GP or lawyer – it could be the individual's family member.

Summary of document

An ADRT is a legally binding document where an individual receiving care can outline treatments they do not wish to receive in the future, even if this treatment were to prolong their life. If someone is refusing a life-sustaining treatment, this needs to be explicitly written in their document. Knowingly contradicting the decisions of an ADRT is consistent with breaking the law.

ADRTs must be made when the individual has capacity, and then come into play when the individual no longer has capacity to make decisions. ADRTs must be written specifically to include a particular treatment, e.g. mechanical ventilation – it is not advised that ADRTs are written as blanket statements refusing all care.

An ADRT does not need to be signed by a GP or a solicitor, but it is a good idea to ensure an individual's GP is aware of the ADRT and has access to a copy.

Roles and responsibilities

All care professionals and managers should be aware if there is an ADRT in place, and alert other professionals about the ADRT as required.

All care professionals should ensure the ADRT is kept safe and secure.

Advanced care planning documents summary:

Name of Document:

Advanced Statements
(also known as Advance Care Plans or ACPs)

Area document is in use

Nationally, however will vary widely in appearance as there is no set criteria for how an advanced statement should look.

Summary of document

An advance statement is an individual's opportunity to record their preferences when coming towards the end of their life. This is not focussed on specific treatments, like in the ADRT, but is more generalised. For example, does the individual prefer a bath or a shower, what foods do they like and what do they like to wear? An advanced statement may also include the funeral preferences of the individual concerned.

Roles and responsibilities

All care staff should know where to find information from an advanced statement. Managers of care providers should ensure that individual's care records are up to date and inclusive of advanced statements. Care staff and managers may be included in discussions about their service users and should make others aware of the advanced statements. Individual's care plans should reflect any preferences stated in advanced statements.

Please note: these are not legally binding documents unlike an Advanced Decision to Refuse Treatment. However, we should still endeavour to uphold these wishes wherever possible.

Advanced care planning documents summary:

Name of Document:

Advance Care Plans (ACPs)
(please also see Advanced Statements section)

Area document is in use

Nationally, however will vary widely in appearance as these depend on the provider's own templates.

Summary of document

Advanced care plans are usually made in conjunction with an individual's healthcare team when they're planning for their future care. These record the individual's treatments and wishes and will include details such as DNACPRs, lasting powers of attorney, and medical details as well. This may also include other wishes such as funeral arrangements, any religious beliefs and preferred places of care and death.

Roles and responsibilities

All care professionals should have an understanding of their organisation's advance care plans and know how to access these. All care professionals should adhere to and uphold the advance care plan for all individuals they support.

Managers should ensure the advance care plans being used by the organisation are robust and are implemented frequently.

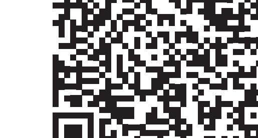
Please note: these are not legally binding documents unlike an Advanced Decision to Refuse Treatment. However, we should still endeavour to uphold these wishes wherever possible.

Advanced care planning documents summary:

Name of Document:

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

To view the document click here or scan the QR code



Area document is in use

East and North Hertfordshire only.

Summary of document

The ReSPECT paperwork is being introduced to East and North Hertfordshire from September 2022. The ReSPECT paperwork is due to replace DNACPRs. ReSPECT is a summary document that details someone's wishes and priorities at end of life, including a decision about DNACPR. ReSPECT forms should be held to the same high standards that DNACPRs are. Further information about ReSPECT can be found here: https://www.resus.org.uk/respect

Roles and responsibilities

All care professionals should have an awareness of the ReSPECT paperwork and what this entails, as well as who has a ReSPECT form and where this is kept.

Managers of care providers should be able to advocate for the individuals accessing their service if a ReSPECT has been filled out inappropriately.

Advanced care planning documents summary:

Name of Document:

Proactive Enhanced Advance Care Plan (PEACE plan)

Area document is in use

West Hertfordshire only.

Summary of document

The PEACE plan is a non-mandatory document very similar to the ReSPECT paperwork, except it does not include a decision about CPR.

This document includes discussions around preferred place of care and death and other preferences around end of life.

Roles and responsibilities

All care professionals should have an awareness of the PEACE paperwork and what this entails, as well as who has a PEACE form and where this is kept.

Managers of care providers should be able to advocate for the individuals accessing their service if a PEACE has been filled out inappropriately.