

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.



East of England

DO NOT PHOTOCOPY

**ORIGINAL
PATIENT COPY TO
STAY WITH PATIENT**

Date of DNACPR order:

Name:	(OR USE ADDRESSOGRAPH)		
Address:			
		Postcode:	
NHS number:		Date of birth:	

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REASON FOR DNACPR DECISION (tick one or more boxes and provide further information)

<input type="checkbox"/>	CPR is unlikely to be successful (i.e. medically futile) because:
<input type="checkbox"/>	Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:
<input type="checkbox"/>	Patient does not want to be resuscitated as evidenced by:

RECORD OF DISCUSSION OF DECISION (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If 'yes' record content of discussion. If 'no' say why not discussed.		
Discussed with relatives / carers / others?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.		
Discussed with other members of the health care team?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.		

Is DNACPR decision indefinite? Yes No If 'no' specify review date:

HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER			
Name:		Signature:	
Position:		Date:	Time:

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN			
Name:		Signature:	
Position:		Date:	Time:

Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?

NO

If there is no reason to believe that the patient is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with the patient (or those close to patients who lack capacity) about CPR. If, however, the patient wishes to discuss CPR this should be respected.

YES

Is there a realistic chance that CPR could be successful?

NO

When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient's wishes about CPR. However if a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it unless that would cause them severe distress. Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation. Where the patient lacks capacity and has a LPA health and welfare or CAD, this person should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussions about the patient's care. If a second opinion is requested, this request should be respected, whenever possible.

YES

Does the patient lack capacity and have an advance decision refusing CPR or a LPA health and welfare with relevant authority?

YES

If a patient has made an advance decision refusing CPR and the criteria for applicability and validity are met, this must be respected. If an attorney or deputy has been appointed they should be consulted.

NO

Are the potential risks and burdens of CPR considered to be greater than the likely benefits of CPR?

YES

When there is only a small chance of CPR being successful and/or there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial.

NO

CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.

PLEASE NOTE: Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully. Advice should be sought if there is uncertainty.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

This leaflet provides guidelines for completing a DNACPR order for adults aged 16 and over. This must be completed by a 'suitably trained' healthcare professional and be endorsed by a responsible senior clinician. The original DNACPR order **MUST** be held by the patient, as a photocopy **will not** be accepted.

The responsible senior clinician (e.g. GP or Hospital Consultant) **MUST** be aware that they have a responsibility to check the information written within the DNACPR (if they haven't fully completed the form themselves) and the need to assess mental capacity where appropriate.

Guidance

The numbers below correlate with the DNACPR overleaf and highlight areas that **MUST** be completed for the order to be valid.

- 1 Name, address, date of birth and date of the DNACPR order - must be completed to enable the healthcare professional to confirm that this order relates to the person they are treating.
- 2 Reason for DNACPR decision - this information will assist the healthcare professional with decision making, particularly if the person is not yet in cardiac arrest.
- 3 Record of discussion of decision - completion of this assists the healthcare professional to identify those who are aware of the decision on arrival at the scene.
- 4 Is DNACPR decision indefinite? One of these boxes **MUST** be ticked, with a date for review of this decision if the order is not indefinite.
- 5 Signature 1 - the healthcare professional completing the DNACPR order should sign and date this.
- 6 Signature 2 - the responsible senior clinician (i.e. GP or consultant) **MUST** sign to validate the decision. If the responsible clinician completes the DNACPR order, their signature is only required in this box, not the box above. **If this box is not signed, the DNACPR order is not valid.**

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East of England

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	1		
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Is DNACPR decision indefinite? Yes No If 'no' specify review date: **4**

HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER

Name:	Signature:
5	
Position:	Date:
	Time:

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN

Name:	Signature:
6	
Position:	Date:
	Time:

My Care Wishes – Personalised Shared Care Plan

Version 20 Feb 2020

This care plan is for you to record your preferences about how you would like to be cared for should you become less well. This form should always be available to you and your care team.

Information About You

Name	GP Surgery	GP Name
Date of Birth	Diagnosis	
NHS Number	Other medical conditions (relevant to your current care)	
Address	Allergies	
Postcode		
Contact Tel. Home: Contact Tel. Mobile:	Frailty Score	
1. Next of Kin/Family Carer Name: Relationship: Telephone home: Telephone mobile:	2. Next of Kin/Family Carer Name: Relationship: Telephone home: Telephone mobile:	

Care Plan Discussion - Who is Helping You With This Care Plan?

Family member or friend involved in this discussion	Name: Relationship: Telephone:
Do you have a Registered Lasting Power of Attorney for Health and Welfare?	Name: Telephone (if not already given):
Health or Social Care professional involved in this discussion eg. Nurse, Senior Carer, Carer, Physiotherapist	Name: Role: Telephone:

Your General Care Needs

Who Supports you?	Name: Relationship: Telephone:
Care Agencies involved	Name(s) Telephone:
What is important for your care team to know how to care for you? e.g. Communication Eating and drinking Swallowing difficulties/Risk based Feeding Moving and Handling, include equipment Skin Care eg Contenance, pressure area care, pressure relieving equipment Equipment e.g. Oxygen	

Your Urgent Care Needs

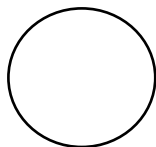
As you become less well and need further treatment, if possible **where would you most like to be cared for?**

Circle your preference

Usual Place of Residence Hospital Other:

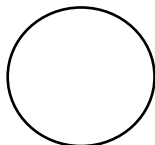
Some situations may benefit from urgent active care (such as sudden bleeding/severe anaemia etc.) Do you have a preference to how your needs might be managed? If you do have a preference, please tick (✓) the circle below that applies to you, knowing that in all situations comfort and symptom control will always be a priority.

Maximum Active Care



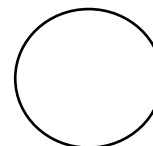
I would like to be actively treated in all situations.

Treat potentially reversible life threatening conditions early



I might like treatment in some circumstances such as sudden bleeding, severe anaemia, worsening kidney function, chest infection.

No Further Active Treatment



I am likely to decline further active treatment, including antibiotics for infection/hospitalisation for urgent care.

Emergency Plan Should Your Carer Become Unwell

What action should be taken should your family carer become unwell?

Action:

Your Final Days

If you become less well and you are not expected to recover, what is the most important thing for you?

Where would you most like to spend your final days?

Circle your preference

Usual Place of Residence: Other:

Do you have a signed and dated DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form?

YES

NO

Do you have 'Just in Case' medications? (To be used should you have new or worsening symptoms for which you require urgent medication)

YES

NO

Your Additional Comments

Do you have any special requests, preferences, or other comments? e.g. faith, spiritual needs, music, pets, favourite possessions

Are there any additional comments from other people you are close to? (please name)

Consent to Share This Information With Your Care Team

Review Date

Your Signature/Registered Lasting Power of Attorney for Health and Welfare

Signature
Date

Name

Health or Social Care professional eg. Nurse, Senior Carer, Carer, Physiotherapist

Signature
Date

Role

Directory of Key Contacts

To help in co-ordination and delivery of end of life care, make a note of contact details for local services and professionals who you may need to call upon.

Would staff please add appropriate numbers marked with * as a priority		
Contact	Details	Additional Information
Local GP Surgery	*	
District Nurses	0300 123 2425	
Early Intervention Team (EIT)	West Suffolk 0300 123 2425	When telephoning, ask for 'EIT' 24/7 availability
Reactive Emergency Assessment Community Team (REACT)	Ipswich and East Suffolk 0300 123 2425	When telephoning, ask for 'REACT' 24/7 availability
Out of Hours GP Provider	111	Available when normal GP surgery is closed (1830-0830)
Specialist Palliative Care Team: • Community Palliative Care nurses	*	
St Elizabeth Hospice	01473 707044 (community secretaries available 0900-1900 weekdays) 0800 56 70 111 (One call palliative care advice line)	For referrals and office hours contact for community teams. 24/7 availability to patients, families and health and social care staff. <i>N.B. These services are able to assist with the management of patients at home/care home.</i>
St Nicholas Hospice Care	01284 702525 01284 766133	For all clinical services 0900-1700 Mon – Fri. This number will also direct you to the clinical mobile number for 0900-1600 weekend and bank holiday support Main reception number, and for all clinical support outside the above times
Hospital (Local)	West Suffolk: 01284 713000 Ipswich: 01473 712233	
Care agency		
Pharmacy		
Marie Curie (Nurse link)		
Advocacy Services – Independent Mental Capacity Advocate (IMCA)		
Social Services		
Equipment Store		
Benefits Advice		
Dementia Intensive Support Team (DIST)	West Suffolk - 01284 733260 Ipswich and East Suffolk – 01473 891733	Monday – Friday 0900-1700
Age UK Suffolk – Information and advice	01473 351234	Monday – Friday 0900-1630
Suffolk Family Carers – Information line	01473 835477	Mon, Weds & Thurs 0900-1700 Tues 0900-1930 Fri 0900-1600
Other		



Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up”, and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

Suggested actions for patients with frailty score 5-6

- Undertake a medication review
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti-hypertensives should be used with caution
- Start new medication at low dose with very gradual increments
- Use personalised goals when applying disease-based guidelines e.g. for diabetes, hypertension and CKD
- Avoid over treating hypertension & diabetes
- Screen for falls and refer to local healthcare team if required
- Check for postural hypotension if falling
- Consider need for calcium/vitamin D if housebound

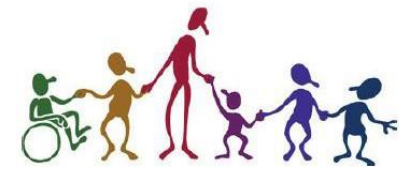
- Refer to community matron if 3 or more long-term conditions
- Discuss with local healthcare team at multidisciplinary meeting
- Generate a personalised shared care & support plan outlining treatment goals and management plans for urgent care
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Consider whether an increase in social care is required

West

Nursing and therapy services (including Community matron) referral no: 0300 1232425
Geriatrician referral no: 01284 713299

East

Geriatrician hotline referral no: 07930 181236 (Mon-Fri, 0900 – 1700)



7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia.

Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Suggested actions for frailty score 7-9

- Undertake a medication review
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti-hypertensives should be used with caution
- Start new medication at low dose with very gradual increments
- Use personalised goals when applying disease-based guidelines e.g. for diabetes, hypertension and CKD to avoid overtreatment
- Screen for falls and refer to local healthcare team if required
- Check for postural hypotension if falling
- Consider need for calcium/vitamin D if housebound
- Ask about memory problems and refer on if indicated
- Consider whether an increase in social care is required

- Refer to community matron if 3 or more long-term conditions
- Discuss with local healthcare team at multidisciplinary meeting
- Generate a personalised shared care & support plan outlining treatment goals and management plans for urgent care
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Discuss the patient's preferences for end of life and complete a DNACPR form if appropriate
- Consider entering patient onto the GSF register

Nursing and therapy services (including Community matron) referral no: 0300 123 2425

Geriatrician referral no: 01284 713299

My Care Wishes – Information Sheet

Version 2 Feb 2020

What is My Care Wishes?

If you are living with a long term or life limiting illness, you may be managing well with the support of your family and/or care team. However, there may be times when you become less well.

It is helpful for your family and care team to know what you would like to happen when you become less well so that the right action is taken.

It is especially helpful to consider what you would like to happen **in an urgent situation**, as you may be too unwell at that time to make a decision. Some treatments can be given in your home, such as taking tablets. Other treatments can only be given in a hospital.

How do I record My Care Wishes?

You should be given the opportunity to have a discussion with a health or social care professional so that if you become less well you know what to expect and can plan your care. This is your personalised shared care plan. The discussion should involve those persons who support you; this could be your family, your friends or your Registered Lasting Power of Attorney for Health and Welfare. If you change your mind about how you would like to be cared for, you should discuss this with the person who knows you best to record the changes.

A health care professional should assess your mental capacity prior to you completing your care plan.

Further information about mental capacity can be found at <https://www.suffolk.gov.uk/mca>

Who can see My Care Wishes?

My Care Wishes records important information about you, which can be shared with your care team so that the care you receive reflects your wishes.

Where should I keep My Care Wishes?

Your personalised shared care plan should be kept in the yellow My Care Wishes folder. This folder should be with you wherever you go, so that it is always available in the event of an emergency. There is a location sticker in the folder for you to state where you keep your folder at home. The sticker should be placed either on the back of your front door, or your fridge.

Other documents in the yellow My Care Wishes folder

It is important that all the information about your wishes are kept together

DNACPR – Do Not Attempt Cardiopulmonary Resuscitation

This form records a decision about whether there should be an attempt to start cardiopulmonary resuscitation should your heart suddenly stop, or your heart stops as you come to the natural end of your life. It is best practice that you, your family and your GP discuss this decision. Cardiopulmonary resuscitation will only be given if the doctor believes it is clinically appropriate. This will depend on your current state of health and other underlying medical problems.

Directory of Key Contacts

You are likely to have a number of health and social care professionals in your care team. You may also have different organisations who support you. The directory of key contacts records all these contact details.

Clinical Frailty Scale

If you are living with a long term or life limiting illness, you can be assessed for your level of frailty. This assessment helps to identify your health needs so that actions are taken to improve your wellbeing.

Further Information

If you are a healthcare professional, further information can be found at <https://www.westsuffolkccg.nhs.uk/>
<http://www.ipswichandeastsuffolkccg.nhs.uk/>