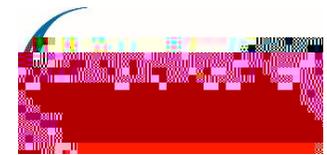




Who makes the ultimate decision about life saving treatment like CPR when a person is critically ill?

DNACPR forms are not legally binding, this means a hospital doctor can review the clinical viability of CPR, taking into account the person's wishes, to decide if DNACPR is still appropriate. The most senior healthcare professional responsible for the person's immediate care at the time, will make the ultimate decision about whether CPR is attempted.

The professional responsible must make sure their decision promotes human dignity and upholds the person's rights according to the Human Rights Act 1998 (ie, the right to life (Article 2); the right to be free from inhuman or degrading treatment (Article 3); the right to respect for privacy and family life (Article 8); 17; the right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and the right to be free from discriminatory practice in respect of these rights (Article 14).)



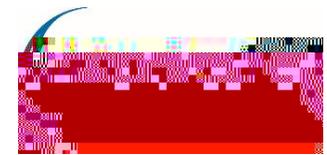
Advance Care Plan (ACP)

What is an Advance Care Plan (ACP)?

An Advance Care Plan (ACP) offers people the opportunity to plan their future care and support, including medical treatment, while they have mental capacity to make these decisions. A DNACPR can be part of this.



	<p>A blanket DNACPR is never appropriate. DNACPR decisions should not be applied to groups of people.</p> <p>Raise concerns with the doctor who signed the DNACPR form or, in an emergency, speak to medical team providing care and treatment.</p> <p>Raise concerns with your local Safeguarding Adults Board.</p> <p>Raise concerns with CQC www.cqc.org.uk/give-feedback-on-care</p>
What does best practice look like?	<p>As a care worker you should support people to think about their wishes and to help them communicate this to the doctor responsible for their healthcare.</p> <p>If someone you care for has a long-term condition or a terminal illness, then you or someone from the healthcare team should talk to them about what they can expect and what treatment options they have. If it's likely that they'll have a cardiopulmonary arrest, then planning what will happen if that situation arises should form part of this conversation, and be discussed with their healthcare professional who would be responsible for authorising a DNACPR decision.</p> <p>Be proactive with personalised end of life care planning, make sure the person is involved in the assessment of their needs, wishes and what is important now and for their future care needs.</p> <p>Be sensitive – some people may not want to talk about this or to have an advanced care plan in place.</p> <p>Be ready at any time to explain the purpose of advance care planning and discuss the advantages and challenges.</p> <p>Together with the person (and their carer or family if they wish), think about anything that could stop them being fully involved and how to make their involvement easier.</p> <p>Think about the person's understanding of illness, death and dying, their communication preferences and ways of processing information.</p> <p>Tailor information to reflect the person's thinking and learning style. Be mindful about the language and phrases used when discussing end of life. (For example, people with a learning disability or cognitive impairment may find the concept of death difficult to understand. Autistic people may find it hard to think about situations they have not yet experienced. Use simple, direct language and</p>



avoid euphemisms that might be taken literally. I.e., don't explain death as going to a better place or going to sleep. (Ref Bereavement – a guide for professionals autism.org.uk). Use naturally occurring situations to gather people's views; for example, when other people or pets die or when watching this happen on TV.

Offer to discuss advance care planning at a time that is right for them.

Make sure you have up-to-date information about the person's medical condition and treatment options to help the process and involve relevant healthcare staff if needed.

There must be comprehensive records of conversations with, and decisions agreed with, people, Make sure that other people involved in the person's care (for example family carers, day services etc.) know about their wishes and decisions that have been made. These must be properly communicated to others who need to know them.

Lead responsible body:

Ensure your service has robust monitoring systems that check DNACPR notices are appropriate and act quickly if they are not.

Ensure you have systems to make sure that people's DNACPRs are stored, reviewed and communicated properly.

Make sure managers and care staff are empowered, through training and supervision, to challenge DNACPR decisions that do not uphold people's rights and dignity.

»f The Resuscitation Council have developed a template as part of the advance care planning