North West Anticipatory Clinical Management Planning Guidance including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Supported by:
North West Ambulance Service
Greater Manchester and Eastern Cheshire Strategic Clinical Networks
North West Coast Strategic Clinical Networks

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PURPOSE OF THIS GUIDANCE

- To 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 (DNACPR), as well as Advance Care Planning, across all health and social care settings;
- To support understanding of the legal requirements of DNACPR documentation;
- To support the use of DNACPR 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 interests. This extends to making decisions about potentially life sustaining treatments on behalf of a person, including decisions about Cardiopulmonary Resuscitation (CPR);
- To support the use, transfer and acceptance of Anticipatory Clinical Management Planning including DNACPR 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 DNACPR decisions.

SCOPE

This guidance focuses on discussions and shared decision making regarding anticipatory clinical management plans rather than the paperwork it is recorded on. This includes Treatment Escalation Plans (TEPs) and Emergency Treatment Plans (ETPs) and decisions about CPR. These are not “decisions made in advance” but they provide guidance which may support clinical decision making at a future date.

Recording of information should be in line with professional record keeping policies and documentation agreed by each organisation.

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 DNACPR orders in acute care settings, including whether resuscitation decisions should be considered in the context of overall treatment plans. In 2021, the Care Quality Commission recommended a consistent approach to Advance Care Planning and this was strengthened through the publication of Universal Principles for Advance Care Planning (2022) with conversations and decisions about cardiopulmonary resuscitation being undertaken in the wider clinical context.

All clinical encounters are opportunities to consider and undertake Anticipatory Clinical Management Planning. Comprehensive Geriatric Assessments, Holistic Needs Assessments and Personal Support Care Planning are examples of holistic assessments which may support Anticipatory Clinical Management Planning for some individuals.

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 recognises Anticipatory Clinical Management Plans as a specific area of future care planning requiring clinical input. Future Care Planning incorporates both Advance Care Planning and Anticipatory Clinical Management Planning (see Table 1).

Table 1, 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

Advance Care Planning is a voluntary process of person-centred discussion between an individual and their care providers about their preferences and priorities for future care. These are likely to involve a number of conversations over time and with whoever the person wishes to involve.

An Anticipatory Clinical Management Plan (ACMP) is a proactive clinical plan, made in advance to guide the management of a future clinical situation, predicted or thought likely to occur. It allows conversations and preparation for the future.

Anticipatory Clinical Management Planning may include Treatment Escalation Plans (TEP), Ceilings of Treatment (CoT), and decisions about cardiopulmonary resuscitation (CPR). Although a shared decision making approach should be adopted where the patient is able, the development of an ACMP is a clinically led process. Where an individual lacks the capacity to make decisions about their future care, a best interest framework should be used to guide planning and decision making which aligns with what is known about the individual's values, beliefs, wishes and preferences for treatment.

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 DNACPR decisions refer to CPR.

This guidance will provide a framework to ensure that ACMPs including discussions and decisions about cardiopulmonary resuscitation:

- 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.

DISCUSSIONS AND DECISIONS ABOUT CARDIOPULMONARY RESUSCIATION

Cardiopulmonary Arrest and Cardiopulmonary Resuscitation

For most 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 Cardiopulmonary Resuscitation (DNACPR) decision to enable the person to live and die naturally and with dignity.

Unexpected Cardiac Arrest

In the event of an unexpected cardiac arrest, all individuals are presumed to be "for CPR" and CPR will be attempted unless:

- The healthcare team are satisfied that CPR would **not be clinically appropriate** in the circumstances because it would not be successful (i.e., the healthcare team are as certain as they can be that a person is dying as an inevitable result of an underlying disease or catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period).
- A valid Do Not Attempt Cardiopulmonary Resuscitation (**DNACPR)** decision has been made and is clearly documented.
- A valid and applicable **Advance Decision to Refuse Treatment** (ADRT), refusing cardiopulmonary resuscitation, is in place and made known.
- It has been concluded, having considered all necessary factors under the Best Interests' checklist, including consultation with the family and significant others, that it would not be in the individual's **best interests** for CPR to be attempted.
    - 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 Mental Capacity Act (MCA), it is nonetheless important to consider the individual's wishes when making a best interest decision regarding CPR. In such circumstances, it is unlikely that it would be appropriate to perform CPR. However, if there is any doubt or dispute as to whether CPR would be in the persons best interests, the balance lies in favour of preserving life and CPR should be attempted.
- Where the individual has an attorney appointed under a valid and applicable (Lasting Power of Attorney (LPA) for health and welfare) who also has the authority to make decisions in respect of life sustaining treatment on their behalf. If the attorney is present at the point of the arrest, this individual will then make any best interest decision regarding CPR. You will need to see the document to ensure it is registered and authorises the attorney to make decisions about life sustaining treatment. (NB – An attorney does not have any power to require CPR where this is not considered to be clinically appropriate by the healthcare team).

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

In the event of registered healthcare staff finding a person with no signs of life, where there is no recorded DNACPR decision, or an ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR. In these emergency situations, there will rarely be time to make a comprehensive assessment of the patient's condition and initiating CPR will usually be appropriate. In certain situations, it would be inappropriate for CPR to be considered or attempted, for instance, where there is evidence of obvious and irreversible death. In all other scenarios, an immediate decision whether to commence CPR must be made. (Some organisations may define other healthcare staff within this section).

In determining whether CPR would be appropriate, consideration of the following factors by healthcare staff 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 attempting 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.

There may be situations where CPR is started. However, during resuscitation attempts, further information becomes available that would make the continued attempts to resuscitate inappropriate. This would include situations where it subsequently becomes apparent that a valid DNACPR decision has been made, or a valid and applicable ADRT is in place. Alternatively, healthcare staff may become aware of clinical information indicating that continued attempts would not be appropriate in the circumstances.

Any decisions made regarding CPR should be clearly documented at the first available opportunity, including decisions to cease CPR attempts. Healthcare staff must include the clinical rationale for their decision-making. Provided the registered healthcare 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.

<u>Decisions about Cardiopulmonary Resuscitation</u>

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

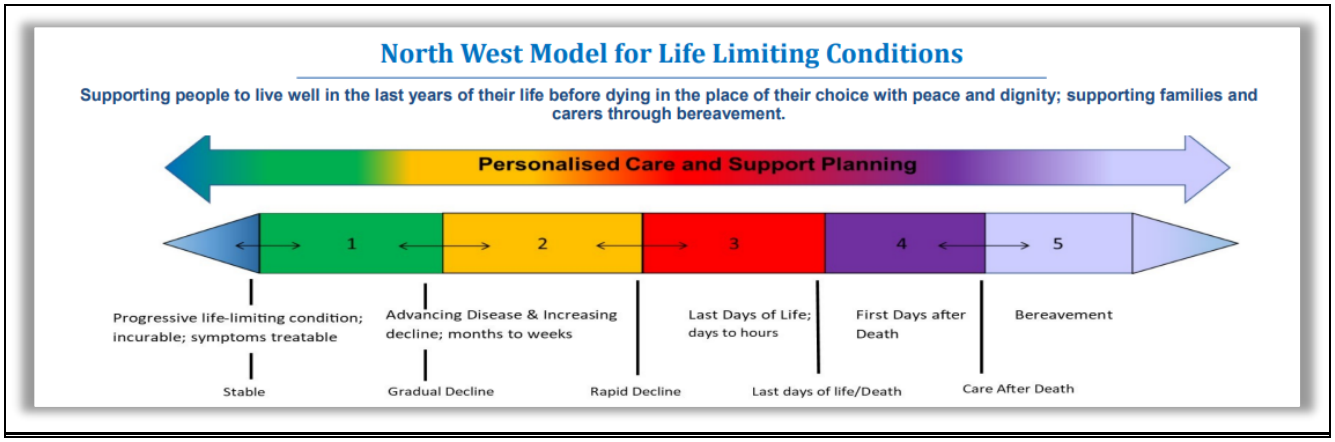
Anticipatory Clinical Management Plan discussions, including that CPR should not be attempted for a particular person, form a recommendation to guide clinicians present at the time of a future cardiorespiratory arrest. A recorded DNACPR decision is not, in itself, legally binding and should be regarded as a clinical assessment and decision, made and recorded in advance, to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest. It is those clinicians, at time of any cardiopulmonary arrest, who must make the clinical decision whether or not to attempt CPR.

Blanket approaches to DNACPR are inappropriate and all decisions relating to CPR should be made based on the individual circumstances.

When considering making a DNACPR 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



NHS England and NHS Improvement North West » North West Model for Life Limiting Conditions

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.

DNACPR DECISION MAKING CIRCUMSTANCES

When a decision about CPR is discussed, made and recorded, clinicians should be clear and open about the basis for the decision. Communicating DNACPR decisions can be challenging for healthcare professionals. However, failure to explain such decisions and the basis for the decision can lead to misunderstanding, as well as potentially avoidable distress and dissatisfaction.

The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) Guidance 2016 “Decisions relating to cardiopulmonary resuscitation” states that decisions about CPR 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) if appropriate - unless there are convincing reasons otherwise (i.e., it would cause physical or psychological harm). This is information sharing only as there is no decision for the individual to make in these circumstances.

In the cases three and four, consultation with the individual will be required. The individual’s views will be paramount in the decision-making process. There should be an open dialogue with the patient and shared decision-making between the individual and professionals. If the patient lacks capacity to make the decision, a best interest decision will be required.

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 Appendix 1).* All DNACPR decisions must be based on current legislation and guidance, in particular, healthcare staff must ensure they comply with the Mental Capacity Act 2005 framework where individuals are assessed as lacking capacity to make decisions regarding life-sustaining treatment.

Resuscitation Discussions with individuals and those close to them – Consulting with individuals with capacity

To comply with Article 8 of the European Convention on Human Rights 1998 health professionals should explain DNACPR decisions, and in cases three and four above individuals should be consulted – the presumption lies in favour of individual involvement in these decisions. Some people will need reasonable adjustments to be able to have this conversation.

Individuals should be informed sensitively about what CPR involves and its possible risks and adverse effects, as well as its likely chance of success in their specific circumstance, so they are able to make an informed decision. All discussions and decisions, including the clinical rationale for decision-making should be clearly recorded.If a potential decision about CPR is deemed inappropriate~~,~~ 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 DNACPR decision has been made on the grounds that CPR will not work (cases one and two) the individual should be **informed** of the DNACPR 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 DNACPR. 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 DNACPR 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. If the individual wishes for this information to remain confidential, this should be respected and recorded within their notes.

A 'decisions around cardiopulmonary resuscitation' 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.

It is only in very rare circumstances that a DNACPR 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.

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 DNACPR 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.

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 understanding of the current clinical situation and anticipated illness trajectory, their expectations of an attempt at CPR, and the reasons behind their request for treatment should be explored and 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 DNACPR decision in these circumstances, despite careful exploration of understanding and expectations and an explanation of the decision, 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 DNACPR 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 DNACPR, is implemented.

Individual who lacks capacity re: Anticipatory Clinical Management Plans including DNACPR decision making

Capacity is time and decision specific. All adults should be assumed to have capacity unless it is established they lack capacity to make the specific decision. The two-stage test for assessing capacity is set out under the Mental Capacity Act 2005.

If an individual is assessed as lacking capacity to make decisions regarding treatment, check whether they have previously made a valid and applicable Advance Decision to Refuse Treatment (ADRT) that refuses the treatment in question (including CPR), or whether they have appointed a person with lasting power of attorney for health and welfare with appropriate authority (i.e., decisions regarding life-sustaining treatment).

In the event a valid and applicable advance decision has been made, this decision must be followed.

In the event the individual has not made a valid and applicable advanced decision, healthcare staff must consult with the Lasting Power of Attorney (LPA) accordingly, having reviewed the relevant LPA paperwork, ensuring that the attorney has authority to make decisions regarding life-sustaining treatment.

If an individual has both an ADRT and a LPA with authority to make decisions about life sustaining treatment, it will be crucial to identify which was made first. If an individual has made an ADRT but subsequently appointed an Attorney with authority to make that decision, the ADRT is no longer valid. If the individual has made an ADRT after signing a LPA, the ADRT overrules the LPA, and the attorney would not be able to give consent to CPR.

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: DNACPR decision making it is necessary to inform the LPA of the decision, whilst in cases three and four the Attorney

should be consulted as though they were the individual themselves and the Attorney must make a best interests decision.

Where there is no LPA or ADRT and where **the individual lacks capacity**, under the MCA 2005 to make decisions regarding Anticipatory Clinical Management Plans, including DNACPR; 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 it is impracticable or inappropriate 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)

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 DNACPR order in cases three and four), a referral should be made 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 DNACPR 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 interest decision.

REVIEW OF DISCUSSIONS AND DECISIONS

Anticipatory Clinical Management Plans including DNACPR 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 and shared with other organisations involved in the patient's care. 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 DNACPR is reviewed, the reviewer must consider whether the person can contribute to the decision-making process.

Anticipatory Clinical Management Plans including DNACPR should always be reviewed if there is : -

- A change of clinical circumstances
- A change of setting

DOCUMENTATION OF ANTICIPATORY CLINICAL MANAGEMENT PLANNING INCLUDING DNACPR DECISIONS

Legal Status of documentation related to Anticipatory Clinical Management Plans including DNACPR

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 into 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.

Documenting Discussions

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

- North West Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR)
- Deciding Right documentation
- ReSPECT – records the persons expressed preferences for their future care and treatment; it constitutes an 'advance statement', rather than an 'advance Decision to Refuse Treatment (ADRT)
- Electronic Palliative Care Co-ordination Systems (EPaCCS)
- Locally developed Anticipatory Clinical Management Plan and Treatment Escalation proformas
- Clinical letters

This list is not exhaustive. Localities should work towards standardisation across settings of how and where decisions are recorded.

Once a plan has been developed and agreed, it must be recorded on the appropriate organisation's clinical documentation, including any specific locality paperwork regarding Anticipatory Clinical Management Plans including DNACPR. Documentation in black and white is acceptable if 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**.

It is important that ACMPs are accessible to all health care professionals who may provide care to the individual. With consent, an ACMP/ DNACPR may be shared with different organisations (primary, secondary and tertiary care, care homes and the ambulance

service). Information sharing may be supported by Electronic Palliative Care Co-ordination Systems (EPaCCS), message in a bottle or other locally agreed processes.

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.

DNACPR 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 DNACPR 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.

Suspension of DNACPR decision

Uncommonly, some individuals for whom a DNACPR decision has been established may develop Cardiac Arrest from a readily reversible cause. In such situation's 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 DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the person if appropriate, will need to take place.

Cancellation of DNACPR Decision

In rare circumstances, a decision may be made to cancel or revoke the DNACPR 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 DNACPR decision to communicate this to all parties informed of the original decision.**

Organisations should provide a mechanism for electronic versions of the DNACPR 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.

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 and the Equality Act 2010.

This guidance will provide clarity for health and social care staff that DNACPR 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 (incorporating the European Convention on Human Rights into UK Law) 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)

GOVERNANCE

Anticipatory Clinical Management Planning including DNACPR decision-making process is implemented monitored and reviewed to ensure a robust governance framework.

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.

Each organisation who implements this guidance is required to carry out an Equality Impact Assessment (EIA) in line with their organisational guidance.

Integrated Care Boards (ICB) 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 DNACPR documentation, record of decision making, and any complaints/ clinical incidents involving the guidance.

AUDIT AND MONITORING

Individual organisations should assure, monitor, and evaluate compliance with this guidance through audit and data collection using Key Performance Indicators (appendix 2). Whilst it is acknowledged auditing this area of work can be challenging it is essential for developing practice and maintaining individual and professional safety.

All organisations will have clear governance arrangements in place which indicate individuals and Committees 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 DNACPR process.

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

All institutions must consider how to store a copy of the Anticipatory Clinical Management Plans/ DNACPR documentation 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 guidance would also recommend compliance with national available audits to improve practice e.g., the National hospital audit and VOICES questionnaire.

ROLES AND RESPONSIBILITIES

This guidance and its forms/ appendices 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 DNACPR decision in the context of an Anticipatory Clinical Management Plan

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 DNACPR 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.

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

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

- Involve the individual, unless there are sufficient reasons not to, or if the individual has stated they do not wish to be consulted or informed of any decision, following best practice guidelines when making a decision
- If appropriate, involve relevant others in the discussion, and/or inform them of the decision
- 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 as 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/ DNACPR 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 DNACPR 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 Officer of each organisation is responsible for:

- Ensuring that this guidance is adhered to
- Supporting unified guidance development and the implementation in other organisations within their locality
- 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 DNACPR
- Staff are trained and updated in managing DNACPR 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
- DNACPR forms, leaflets and guidance are available as required.

EDUCATION AND TRAINING

Training at a local/regional level must be available to enable staff to meet the requirements of this guidance (appendix 3)

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 situations have a potential to occur.

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 DNACPR decision has been made.

Decision making professionals should complete the recognised competency training designed by each organisation and be indemnified by their organisation.

DISCHARGE/TRANSFER PROCESSS

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 from a 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 DNACPR 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 DNACPR 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 DNACPR 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 DNACPR decision, subject to any change in circumstances.

Current discharge letters should include information regarding Anticipatory Clinical Management Plans including DNACPR 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 DNACPR 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 in that care setting.

A NWACMPG summary page is available (appendix 4)

GLOSSARY OF TERMS:

Advance Care Planning (ACP)	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 & Wales) a legally binding refusal of a specific treatment (ADRT). As such, it is broader than, but includes, 'emergency treatment planning' (see below). Please refer to the Mental Capacity Act 2005, and local policy, for further information.
Advance Decision to Refuse Treatment (ADRT)	***Advance Decision to Refuse Treatment (ADRT):*** 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. 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. 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.
Advance Statement	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.
Best Interests	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'. 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.
Cardiorespiratory arrest	***Cardiorespiratory Arrest (CA)*** 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.
Consent	The process by which a person, with the mental capacity to do so, accepts a treatment that is offered to them. 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.
Cardiopulmonary resuscitation (CPR)	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.

	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.
Comprehensive Geriatric Assessment	A multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan to maximize overall health with aging.
A Court Appointed Deputy	Appointed by the Court of Protection, to make decisions in the Best Interests of those who lack capacity but they **cannot** make decisions to refuse the provision or continuation of life-sustaining treatment.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision	***Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)*** 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. 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 & Wales) this is not, strictly speaking, a 'decision', but a recommendation to guide clinicians present at the time of a future cardiorespiratory arrest. 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.
Emergency treatment decisions	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 *'emergency treatment plans'*, below.
Emergency Treatment Plans – also known as Treatment Escalation Plans (TEPs)	The term given to a written record of a shared decision- making process about care and treatment in a future emergency situation.
General Practitioner	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.
Health and Social Care Staff:	Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.
Healthcare professional with overall clinical responsibility (Sometimes referred to as the senior responsible clinician)	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.
Healthcare setting	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.
Health records	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.
Independent Mental Capacity Advocate (IMCA):	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.
Lasting Power of *Attorney (LPA)*	***Lasting Power of Attorney (LPA)***: 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. 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.
Potentially life- sustaining treatment	Any medical treatment that, in the judgement 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).
Mental Capacity	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 do any of the following: ▪ Understand information relevant to the decision provided to them in the most appropriate way for the individual; or ▪ Retain that information for long enough to make a decision; or ▪ Use or weigh that information as part of the process of making the decision; or ▪ Communicate the decision, whether by talking or sign language or by any other means.
Mental Capacity Act 2005 (MCA)	The ***Mental Capacity Act 2005 (MCA*)** 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. The law in England & 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.
Nominated deputy	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.
Provider organisation / healthcare provider organisation	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.
Personal care support plan	Personalised Care and Support Planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document	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.
Respiratory Arrest	The cessation of normal respiration due to failure of the lungs to function effectively.

REFERENCES

British Geriatric Society Comprehensive Geriatric Assessment toolkit

Care Quality Commission (2021). Protect, Respect, Connect. Decisions about living and dying well during Covid-19

Department of Health & Social Care (2022) Universal Principles for Advance Care Planning

Equality Act (2010) Legislation.gov.uk

House of Commons Health Committee (2014-15) End of Life Care: Fifth Report of Session. Printed 10 March 2015

Human Rights Act (1998) Legislation.gov.uk

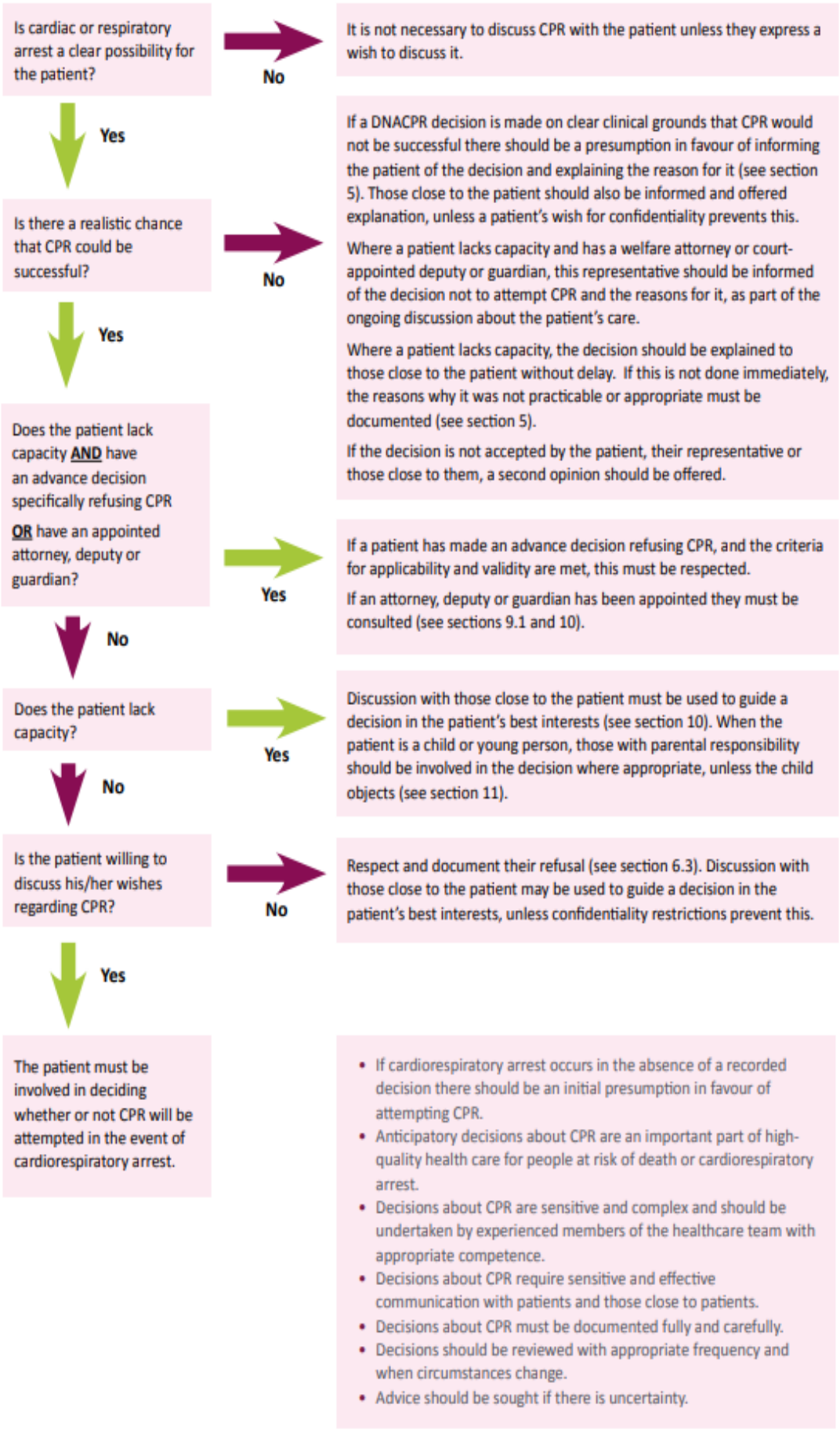
Mental Capacity Act (2015) Legislation.gov.uk

NHS England (2019) Universal Personalised Care: Implementing the Comprehensive Model
NHS England (2022) Universal Principles for Advance Care Planning

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

Appendix 1. Decisions relating to cardiopulmonary resuscitation

Decision-making framework



Appendix 2. Insight metrics for NW ACMP guidance

In the report, Protect, Respect, Connect – decisions about living and dying well during Covid-19, The Care Quality Commission, made recommendations to support future care planning and decisions about CPR. These recommendations form the basis for these insight metrics for the NW ACMP guidance.

The Integrated Care Systems (CQC)

1. There must be guidance for a person-centred approach to Anticipatory Clinical Management Planning (ACMP), which includes guidance about at cardiopulmonary resuscitation (CPR) attempts.
2. There are systems to enable digital compatibility between providers enabling the sharing of real-time updates to Anticipatory Clinical Management Planning, which includes guidance about cardiopulmonary resuscitation attempts.
3. There in an agreed dataset and insight metrics to allow monitoring and assurance of the quality and safety of guidance about cardiopulmonary resuscitation attempts.

Provider Organisations

1. All establishments responsible for discussions and decisions about cardiopulmonary resuscitation attempts should have a policy about Do Not Attempt Cardio-Pulmonary Resuscitation DNACPR decisions (CQC)
2. There are clear processes for DNACPR decisions and AMCPS to support:
   i Making the decision
   ii Documenting the guidance and how it was made
   iii Communicating the decision with patients and families
   iv Sharing the decision with other organisations
   v Reviewing the decision
3. There is robust training available to staff who make advance decisions regarding cardiopulmonary resuscitation attempts and undertake anticipatory clinical management planning.
4. There are systems in place to assure the quality of advance DNACPR guidance and advance care planning. This should include:
   i Systems to assure the quality of advance DNACPR decisions
   ii Systems to evaluate and learn from incidents
   iii An open culture where complaints and concerns can be managed openly.

Documentation review (ACMP)

When an Anticipatory Clinical Management Plan (ACMP) is developed:

1. The patient's capacity to be involved in advance decisions and the development of guidance about future care and treatment at that time, should be assessed and documented, in line with the principles of the Mental Capacity Act
2. When an ACMP is developed, the anticipated clinical event, and the possible options for treatment should be clearly identified and documented.
3. The development of an ACMP should involve the patient. Conversation with the patients and/or those important to them should include an exploration of current understanding and expectations, discussion of the anticipated clinical event and treatment options for that event, and an exploration of the patient's wishes and preferences. The details for such conversations should be documented.
4. If the patient is not able to be involved in decision making at that time due to impaired cognition, their previously expressed wishes and preferences for treatment should be explored (existing future care planning, previously documented conversations, discussion with those identified as important to the individual).
5. The ACMP should be communicated to other health care teams involved in the care of the patient (including ambulance service).
6. Where there is disagreement between the clinician and the patient or family, a second opinion should be sought.

Documentation review (DNACPR)

When a decision regarding cardiopulmonary resuscitation attempts is made:

1. The patient's capacity to be involved in decisions about resuscitation at that time should be assessed and documented, in line with the principles of the Mental Capacity Act

2. Where a decision is made following the principles of best interest decision making, the reason for this, including details of how the patient's preferences were taken into account, and how the advance decision was reached should be documented.
3. The advance decision regarding cardiopulmonary resuscitation should be communicated with the patient and their families.
4. Conversations regarding cardiopulmonary resuscitation advance decisions should be documented.
5. The advance decision should be communicated to other health care teams involved in the care of the patient (including ambulance service)
6. The advance decision should be made / reviewed by the senior clinician responsible for care.
7. Where there is disagreement between the clinician and the patient or family, a second opinion should be sought.

References

Care Quality Commission. Protect, respect, connect – decisions about living and dying well during Covid-19. 2021

Resuscitation Council UK. Decisions relating to cardiopulmonary resuscitation, 3rd edition-1st revision

Appendix 3. Education and Training

The complexity of anticipatory clinical management planning requires skilled and experienced clinicians to lead sensitive conversations and plan for anticipated clinical events. Clinicians require both core skills, such as advanced communication skills and a working knowledge of the Mental Capacity Act, and an understanding of the processes which support anticipatory clinical management planning and advance decisions about cardiopulmonary resuscitation. They need to be able to provide guidance for future care that is patient-centred and considers the clinical, legal and ethical dimensions of care (see table 1).

All clinical staff require an awareness off Anticipatory Clinical Management Planning with training tailored to their role (see table 2). Training for clinicians who have conversations with patients and those important to them relating to ACMPs and decisions about CPR should be interactive (with face-to-face or facilitated on-line discussion) and delivered by senior clinicians experienced in making decisions about cardio-pulmonary resuscitation and developing Anticipatory Clinical Management Planning. Mentoring and clinical supervision must be made available to clinicians whilst they are developing the skills required to support these processes.

Table 1. Training which supports the development of ACMPs and decisions about CPR

	Present	**Future**
Personal		**Advance Care Planning** Training available: • ACP training, for example the Mayfly Programme or equivalent • eELCA
Clinical	**Clinical Decision Making in Clinical Uncertainty:** • Treatment Escalation Plans • AMBER Care Bundle	**Anticipatory Clinical Management Planning** (decisions about Resuscitation, treatment escalation plans etc) Training required: • Clinical Decision making • Managing clinical uncertainty • Treatment escalation plans • Anticipatory Clinical Management Plans • developing ACMPs (including systems for supervision & mentoring) • Resuscitation decisions • Professional guidance & the law • Competencies for decisions relating to Cardio-Pulmonary Resuscitation
Common skills: Important conversations (Advance Care Planning) Exploring patients' wishes and preferences Communications skills training (Enhanced, advanced, intermediate) Decision making and conversations in critical situations with limited reversibility Discussing uncertain recovery Breaking bad news Clinical Decision making where recovery is uncertain Working within the Mental Capacity Act		

Table 2. Training framework for Anticipatory Clinical Management Planning and decisions about cardiopulmonary resuscitation.

Subject	Objectives for all staff	Additional Objectives for clinical staff who work with patients requiring EoL care within their roles	Additional objectives for those regularly providing palliative care
Anticipatory Clinical Management Planning Anticipatory Clinical Management Planning is the clinical element of Future Care Planning. An Anticipatory Clinical Management Plan (ACMP) is a proactive clinical plan, made in advance to guide the management of a future clinical situation, predicted or thought likely to occur. It allows conversations and preparation for the future. Anticipatory Clinical Management Planning may include Treatment Escalation Plans (TEP), Ceilings of Treatment (CoT), and guidance about cardiopulmonary resuscitation attempts (CPR).	**To recognise that Anticipatory Clinical Management Planning enables clinicians to make plans which may support anticipated events**	**To be able to identify specific clinical events which may occur within a patient's illness trajectory and support clinical planning to support the patients care at a later date** ***"Think about it"*** Be able to identify anticipated events in patients where clinical recovery is uncertain, or the individual has a life-limiting condition. Be able to assess an individual's ability to be involved in decisions about their care following the principles of the mental capacity act. (needs expansion to the other elements of the Mental Capacity Act) ***"Talk about it"*** be able to discuss sensitively with an individual their understanding of their current clinical situation, their anticipated illness trajectory, and their expectations of proposed treatment options in order to gain an understanding of their wishes and preferences about future treatments. Understand the national guidance and legal framework relating to decisions about Cardio-pulmonary resuscitation. ***"Document it, share it"*** Be able to clearly document and ACMP and know the processes for sharing within your place	**To be able to support with complex Anticipatory Clinical Management Planning** Be able to support patients, those important to them, and other health care professionals where there are conflicting views about the whether a particular treatment, including an attempt at CPR, is appropriate for that individual. Be able to lead decision making when there are complex clinical and moral dilemmas. To demonstrate the competencies required to make decisions relating to cardiopulmonary resuscitation*. * Decisions relating to cardiopulmonary resuscitation are the responsibility of the clinician responsible for care (this is usually a Consultant in hospital settings, and the patients General Practitioner in the community). The responsibility should only be delegated to a health care professional who has demonstrated the competencies to have this conversation and make a decision which guides future treatment.

Table 2 - Key references

British Medical Association, Resuscitation Council (UK) & Royal College of Nursing. Decisions relating to cardiopulmonary resuscitation (2016)
Care Quality Commission. Protect, respect, connect (2021)
General Medical Council. Decision making and consent (2020)
General Medical Council. Treatment and care towards the end of life (2010)
Mental Capacity Act (2005)

Advance Care Planning Mayfly day
Decision making and conversations in critical situations with limited reversibility

Appendix 4. Summary of Key Elements of North West Anticipatory Clinical Management Planning Guidance Including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

An Anticipatory Clinical Management Plan (ACMP) is a proactive clinical plan, made in advance to guide the management of a future clinical situation, predicted or thought likely to occur. It allows conversations and preparation for the future and is the clinical element of Future Care Planning.

The Key Elements of Anticipatory Clinical Management Planning	
"Think about it"	Being able to identify anticipated clinical events for patients where clinical recovery is uncertain, or the individual has a life-limiting condition, enables planning which guides how those events may be managed in a crisis.
"Talk about it" Discussions & decisions	Sensitive, honest discussions with an individual and those important to them, about their understanding of the current clinical situation and anticipated illness trajectory and their expectations of proposed treatment options, enables them to consider their wishes and preferences about future treatments. This informs plans developed to guide clinical decision making at a future date.
"Document it" Developing a plan	There are a number of different local and national processes which support the documentation of conversations and ACMPs: It is advised to use standardised documentation across each locality. Decisions and their documentation will reflect the differing and evolving needs of individuals. ACMPs and decisions about CPR attempts require ongoing review.
"Share it"	Individuals often receive care across different organisations and care settings. Robust processes are required to ensure all clinical teams, including out of hours and ambulance services, have timely access to up-to- date information.

The building blocks of Anticipatory Clinical Management Planning, including decisions about Cardiopulmonary Resuscitation*.

Competent Clinical discussions & decisions

Experienced clinicians, with the knowledge & skills to have sensitive & honest conversations and understanding of the clinical, legal & ethical implications of anticipatory clinical management planning and decisions about CPR.

Legislation

Decisions about CPR attempts and ACMPs should be developed in line with the principles of the Mental Capacity Act.

Information sharing

ACMPs and CPR decisions must be shared with the patient, patients' families where appropriate, and with organisations involved in their care.

Education

Robust education programs must support

- Advanced communications skills
- Resuscitation decisions
- Anticipatory Clinical Management Planning
- Managing Clinical Uncertainty
- Treatment Escalation Plans
- Professional guidance & the law
- Medical ethics

Governance

Provider organisations require policies & processes to support Anticipatory Clinical Management Planning, There must be clear processes to monitor and review practice through data collection, audit and mortality review.

Documentation

Anticipatory Clinical Management Plans and Decisions about cardiopulmonary should be clearly documented in a standardised way across each locality and in a way which ensures they are easily identified across hospital, community, care home, hospice and to the Ambulance service.

For further information see the full North West Anticipatory Clinical Management Planning Guidance, v2, 2022.