ANTICIPATORY CARE PATIENT ALERT (ACPA) FORM

GUIDANCE PACK

Version 1.5
Last Update: 19th August 2009
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Anticipatory Care Patient Alert Form

1. Introduction

The Anticipatory Care Patient Alert (ACPA) Form has been designed in consultation with a number of multi-professional representatives from all CHPs. The document has been designed to provide the core information required to aid decision-making about the admission of patients to hospital should their condition deteriorate.

The Anticipatory Care Patient Alert (ACPA) is a one page document which provides specific information on what the preferred plan of action is in the event of a crisis of either a health or social care nature. It is envisaged that whilst this document can be used as a stand alone document, it would benefit from being interpreted in conjunction with other information/documentation available in the patient's notes.

Copies of the DNAR form and Adults with Incapacity Act Form are included in this pack together with guidance notes for completion.
Also included in the pack is some further information on Powers of Attorney. This information can be copied and provided to the patient and/or their family when discussing power of attorney issues.

2. Who Can/Should Complete the Form?

The form is designed in such a way that it can be completed by any healthcare professional who is directly involved in the care of the patient. Additionally, the form will benefit from being completed using a multi-professional/multi-agency approach to ensure all sections are completed fully.
If the form is completed by a healthcare professional other than the patient's GP, it must be sent to the GP for counter signing before being shared for wider access (e.g. inputted into Adastra/copies made for patient's home). This helps to provide overall ownership of the information on the form and ensures that information is not updated/changed by different people without the knowledge of the GP.

3. Guidance for Completion of Form

3.1 Core Data:

- Patient's Name, Address & Tel Number: Please ensure this is completed in all cases
- Date of Birth & CHI Number : Please ensure this is completed in all cases
- Keypad Number: To be completed if patient has a call aid (keypad number should be available from home care contact)

- Carer/family contact & Telephone Number: Please ensure any carer/family contact is aware that they are named on this form
- Additional Keyholder & Telephone Number: Please ensure any keyholder contact is aware that they are named on this form
- Named Community Nurse, GP Practice, Home Care Contact and Help Call Contact Number: Please ensure this information is completed as fully as possible

3.2 Significant Diagnoses/Medication/Allergies:

- Significant Diagnoses to include a brief history of the patient's main conditions and a brief summary of the patient's recent admission history if available/ applicable.
- Current Medication: If the medication prescribed cannot all be named in the space provided, please comment in box to refer to Drug Kardex, Emergency Care Summary (ECS) etc. There is a section on the form further down requesting information on rescue medications kept in the house
- Allergies: If numerous, please cross refer to ECS.

3.3 Plan if Current Condition(s) Deteriorate?

The information provided in this section will vary depending on the individual patient but in general the following principles should be considered.

- Plans should reflect the best clinical and social care for the patient
- Plans should reflect local capacity for delivery
- Plans should be discussed with relevant multi-professional colleagues involved in the care of the patient
- Plans will aim to reduce the need for hospital admission in the first instance, however when admission is unavoidable, ensure the admission is as close to the patients home as possible and keep the length of stay in hospital to a minimum
- Where a hospital admission is anticipated, the length of stay should be estimated

3.4 Other Anticipatory Care Plans/Packages:

- Patient Held anticipatory care plan: Please tick if anticipatory care plan (e.g. Liverpool Care Pathway, self management plan etc) is already in place, and if so where is this held
- Rescue Medications: Please indicate if rescue medications (e.g. Just in Case Boxes) are kept in the house, and if so, what these medications are.

3.5 Capacity Issues:

- Has the Patient Arranged Power of Attorney: Please indicate; if the answer is no, it is good practice to discuss with the patient and/or family the benefits of arranging this before a crisis occurs

- Has the patient Welfare Guardianship: As above; if yes, please provide name and contact number of person with welfare guardianship

3.6 End of Life:

- Have end of life choices been discussed?: The rationale for this is to build on the principles of the Gold Standards Framework for patients who you would not be surprised if they died within the next 12 months.
- Has Resuscitation been discussed?: Please indicate if it has been discussed with the patient and family (two separate tick boxes). If Do Not Resuscitate has been agreed, please ensure that a DNAR form has been completed and faxed to the Hub.
- Further information on DNAR Forms and patients' decisions about resuscitation issues can be found in Section 7 and Appendices 2, 3 and 4.

3.7 Alternative Care Arrangements

- What is the plan should the main carer fall sick?: Are there alternative arrangements already in place, and how quickly can these alternative arrangements be implemented?
- What is the preferred place of care? : This should be at home wherever possible; if hospital admission is necessary, please ensure the hospital is as close to the patient's home as possible and is appropriate for the management of their condition

3.8 Patient Consent

- By signing the form, the patient is consenting to the information contained on the form being shared with other Health and Social Care Professionals, including Out of Hours, SAS, NHS24 etc.
- If the patient is unable to sign the form, please indicate whether witnessed consent was given. Alternatively, if the patient is unable to give consent, please ensure that an Adults with Incapacity Act form has been completed and a copy kept in the Patient's notes.
- Further information on Adults with Incapacity Act forms can be found in Section 8 and Appendices 5 and 6.

3.9 Date Completed/Updated

- As indicated above, the form can be completed by any healthcare professional involved in the direct care of the patient. The form must however be signed by the patient's GP before it is shared with other Professions/Agencies (i.e. inputted on Adastra/ copy given to patient etc.)
- The date that the form is completed or updated must be entered to ensure that current versions of the form are in use at all times and previous paper/scanned versions destroyed.

3.10 Method of Identification of Patient

- Please identify how the patient was identified as requiring or benefitting from the completion of an ACPA. This information is required for payment

and verification purposes to ensure correct payment in accordance with the Local Enhanced Service SLA.

- In the majority of cases an ACPA form will be completed as the patient will either have appeared on the SPARRA list or will be a care home resident. In a small minority of cases however Practices may have used an alternative method of identifying patients at greatest risk of unscheduled admission and this method should be specified on the form. Prior explicit approval is required before an alternative method of identification is used.
- Please see Section 10 for separate guidance on the different methods for identifying patients at greatest risk of unscheduled admission.

4. Format of Form/Sharing with the Highland Hub

The ACPA form will be available electronically as a word document which can be printed out and photocopied for multiple use. Any changes to the form will be notified to Practice Teams and the version number updated in the footnote.
A paper copy of the form must be completed with the patient's signature and scanned into the GP Practice Notes as a record of explicit patient consent for the information to be shared with other health and social care professionals.

A template of the ACPA is also available on the Adastra Out of Hours System. The information contained on the form should be inputted into the Adastra system in a timely manner to ensure this up to date information is shared with both the Highland Hub and NHS24.

Faxed copies of paper forms will only be accepted by the Highland Hub in exceptional circumstances and if access to the Adastra system is unavailable for any reason.

Separate guidance on how to input data onto the Adastra system will be provided by the Highland Hub.

5. Location of Forms

It is important that the information on this form is available for all health or social care professionals who may be involved in the care of the patient, both in and out of hours. For this reason, it is the responsibility of the GP who has signed the form to ensure that a copy is kept at the following locations:

a. Patient's home (paper copy); please ensure its location is clearly identified
b. The Patient's notes in the GP Practice (scanned copy)
c. The nearest A&E or PCEC to the patient's home (through Adastra)
d. The Highland Hub/NHS24 (through Adastra)

Once the information is inputted onto Adastra, the system will 'red flag' the patient record as per the current practice for the Gold Standard Framework for Palliative Care patients. This will ensure that GPs or other professionals called out of hours will be aware of the existence of an Anticipatory Care Patient Alert Form.

6. Review of Anticipatory Care Patient Alert Forms

When a form is reviewed and/or updated, the review date must be recorded on the Adastra system and any amendments to the record changed on the system. Additionally, the most recent version of the form must be scanned into the Patient's Notes in the GP Practice. It is good practice to also keep an updated copy in the patient's home however it is recognised that if the plan is being updated regularly (i.e. daily or weekly), this may not always be practical.

The review period for the Anticipatory Care Patient Alert Forms will vary depending on the complexity of the patient's needs and how stable their current care package is. However, as a rule plans should be reviewed at least every six months or sooner if there is a substantial change to the patient's condition, including an unplanned hospital admission. At every review of the ACPA form, the patient's DNAR status should also be reviewed and any changes notified to the Hub as soon as possible.

If a patient who has an ACPA form dies, please delete the ACPA form from the Adastra system and inform the Hub as soon as possible so that they can amend their records and inform the Scottish Ambulance Service if required (to amend their DNAR records).

7. DNAR Form/Resuscitation Decisions

In certain circumstances, and in discussion with the patient and family, it may be decided that resuscitation is not appropriate and a DNAR form must be completed on all these occasions.

If an advance decision is made that CPR will not be attempted, please read the enclosed guidance notes and CPR Policy (Appendix 3 and Appendix 4) prior to completing the form.

The completed DNAR form must be faxed to the Highland Hub on 01463 732 079 and should be subject to regular review where changes in the patient's condition dictates. In addition, documented evidence of a review of the DNAR form must be included as part of the review process for the Anticipatory Care Patient Alert form (see Section 6 above).

It is also good practice for a copy of the DNAR form to be kept in the patient's home (alongside the ACPA form). If this is to occur, then the DNAR decision **must** be discussed with the patient and explicit consent given by the patient for the form to be held in the home.

Further information on discussion regarding resuscitation decisions with the patient and/or their family is provided below (*taken from the new NHS Highland DNAR Policy [2009 Draft]):*

Discussion with the patient and/or their family regarding resuscitation decisions should take place '*if it is possible to anticipate circumstances where cardio-pulmonary arrest seems likely. Where the patient is competent to make a decision, sensitive, honest and realistic discussion about CPR and its likely outcomes should be undertaken with the patient by an experienced member of the clinical team unless the patient makes it clear they do not wish to have this discussion*.

If it is not possible to anticipate circumstances where cardio-pulmonary arrest might happen, it is assumed that there is no clinical DNAR decision to make and discussions about CPR should not be initiated with the patient or their family, unless the patient expressly wishes to discuss resuscitation issues'.

8. Adults with Incapacity Form

If a patient is unable to give explicit or witnessed consent to the information contained in the ACPA form being shared with other health and social care professionals involved in their care, an Adults with Incapacity Form should be completed. This form is a certificate of incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000, and allows the medical practitioner to treat the patient, applying the principles of the act. Further guidance on the completion of the form can be found in Appendix 6 and a copy of the certificate should be kept in the patient's notes.

9. Power of Attorney

The ACPA form includes information about whether the patient has arranged power of attorney. The appointment of a continuing power of attorney (for property and financial matters) and a welfare power of attorney (for personal and health care) should be encouraged wherever possible whilst the patient still has the capacity to make these decisions and undertake to appoint an appropriate individual/ individuals.

Information on appointing power of attorneys is available in Appendices 7 and 8 and in further attached pdf files. This information can be copied for the patient and their family for taking this process forward. Additionally, website addresses for obtaining further advice and support can be found in Appendix 9

10. Access to SPARRA Data & Other Methods for Identifying Patients at Risk

Patients who would benefit from having an ACPA form should be identified through the SPARRA data. SPARRA stands for **S**cottish **P**atients **a**t **R**isk of **R**eadmission and **A**dmission and is an algorithm that uses the patient's demographics and previous hospital admission history over the past 3 years to

calculate a percentage score of their risk of admission or readmission. SPARRA data is produced by the Information Services Division Scotland (ISD Scotland) and is updated on a quarterly basis.

Access to the most up to date SPARRA data for each Practice will be available through the GP Portal site on the NHS Highland Intranet. A guide on how to access this information through the Intranet is available in Appendix 10.

All practices should use SPARRA as the main source for identifying the top 1% of practice patients at greatest risk of emergency admission. Practices should start at the top of the SPARRA list (ie. those patients with the highest risk score) and work systematically down the list until a 1% practice population threshold is reached. Patients identified on the SPARRA list within the top 1% total should only be excluded if:-

a. The patient is on the Palliative Care Register and their anticipatory care needs already covered by the Palliative Care DES.
b. The patient has since died
c. The patient is no longer registered with the practice
d. A patient with a higher risk score is identified through another case finder tool (see below).

Those Practices (approximately 20 across NHS Highland) that have access to the Nairn Case Finder tool, should compare the patient names on both the SPARRA and Nairn case finder tools up to a limit of 1% of their practice population. It is expected that the majority of names will appear on both lists and these should all be included in the 1% of practice population (unless they meet the following exclusions above). If there are patient names that only appear in one of the case finder tools, it is expected that Practices make a clinical decision as to which patients would benefit most from having an anticipatory care patient alert form completed. Ideally this decision should be taken in a multidisciplinary way, in conjunction with those members of the health and social care team involved in the care of the practice's patients.

There may be a small number of Practices that already have a co-ordinated and structured approach to identifying patients at greatest risk of emergency admission that would benefit from having an ACPA completed. If these Practices wish to continue to use this method to identify the top 1% of their practice population, they must obtain explicit consent from one of the Long Term Conditions Team[1] prior to using this method for the anticipatory care enhanced service. Consent for using a different method of case finding will only be given if the following processes can be demonstrated:

a. Patients are identified using a structured and systematic format (e.g. using disease registers, prescribing information, social care input). Patients

[1] LTC Team: Alexa Pilch (Programme Manager): alexa.pilch@nhs.net; Dennis Tracey (Clinical Lead): dennis.tracey@nhs.net; Christian Goskirk (North CHP): Christian.goskirk@nhs.net; Sue Menzies (Mid CHP): sue.menzies@nhs.net; Gavin Sell (S East CHP): gavin.sell@nhs.net; Maggie Clark (A&B CHP): maggie.clark2@nhs.net

identified without a defined rationale as to why they should be included will not be approved for inclusion.

b. The process for identifying and agreeing patients at greatest risk of unscheduled admission should be multidisciplinary with demonstration that a team based approach to identification has taken place (e.g. documented multidisciplinary meetings).
c. The patient names identified by this alternative method of case finding should be compared against the published SPARRA list for the Practice. Approval will only be given to an alternative method if there is significant cross over of patient names between the two case finding tools.

APPENDICES

NHS Highland Anticipatory Care Patient Alert

Patient's Name: Address and Post Code: Date of Birth: CHI: Telephone No.: Keypad number (if relevant):	Carer/family contact : Telephone No: Additional Keyholder: Telephone No: Named community Nurse : GP Practice: Home Care Contact: Help Call contact number (if available):
Significant Diagnoses:	Current Medication: Allergies :

What is the plan in case current condition(s) deteriorate(s) ?

Is there a patient held anticipatory care plan? Yes ☐ No ☐

Are rescue medications kept in the house (eg steroids, antibiotics) Yes ☐ No ☐
If so, please list here :

Has the patient arranged power of attorney? Yes ☐ No ☐
Has the patient Welfare guardianship? Yes ☐ No ☐
Contact details of person with Welfare Guardianship

Have end of life choices been discussed? Yes ☐ No ☐
If a living will is in place, who holds copies?

Has Resuscitation been discussed with the patient Yes ☐ No ☐ and Family Yes ☐ No ☐
Is resuscitation appropriate ? Yes ☐ No ☐
Has Do Not Resuscitate been agreed ? Yes ☐ No ☐ If so, has DNR form been faxed to Hub Yes ☐ No ☐

What is the plan should the main carer fall sick?

What is the Preferred Place of Care?

If hospital admission is necessary, which hospital should be first choice?

I have read the above information and give my consent for this information, and any updates, to be shared within the Highland Out of Hours Service and other Health or Social Care Professionals.

Patient Name:	Patient Signature:	Date:
GP Name:	GP Signature:	Date:

If the patient is unable to sign this, have they otherwise given their witnessed consent Yes ☐ No ☐
If the patient is unable to give consent, has the Adults with Incapacity Act form been completed Yes ☐ No ☐

Date Completed/Updated.....

Method of Identification of Patient *(for payment purposes)*:
SPARRA☐ Care Home☐
Other ☐ (please specify): .....

Please ensure information from form is inputted onto ADASTRA system and changes at Reviews made on the system.
If ADASTRA is unavailable, fax/email to the Highland Hub 01463 732 079/ mariee.mackinnon@nhs.net

DO NOT ATTEMPT RESUSCITATION (DNAR)

NHS Highland

Please refer to the policy and guidance notes when completing

Patient's name …… CHI number ……..

Address …….. Date of Birth ……. / …… /……..

A decision has been taken that Mr/Mrs/Ms …… is not for cardiopulmonary resuscitation (CPR)

This decision has been made because: *(please tick appropriate boxes)*

☐ The patient's condition indicates that CPR is unlikely to be effective, or successful CPR is likely to be followed by a length and quality of life which would not be acceptable to the patient.

☐ CPR is not in accord with the recorded, sustained wishes of a patient who is mentally competent.

Communication:

☐ The decision has been discussed with the patient

☐ The decision has not been discussed with the patient (Please state reason below)

……

☐ The decision has been discussed with a person close to the patient

Name …….. Relationship ……..

GP's Name …… Date …... / …... / …. .. Time ……

Practice Address ……

GP's Signature ……

Review Date		**GP Signature**
…… / …… / ……	**DNAR remains**	**DNAR cancelled ……**
…… / ….. / …….	**DNAR remains**	**DNAR cancelled ……**
…… / ….. / …….	**DNAR remains**	**DNAR cancelled ……**
…… / ….. / …….	**DNAR remains**	**DNAR cancelled ……**

Display this form on the inside front cover of the patient's medical notes.

PLEASE SEND AND/OR FAX TO: HIGHLAND HUB, c/o Scottish Ambulance Service, Raigmore Gardens, Inverness, IV2 3UL : FAX NO. 01463 732079 : TEL NO: 01463 732073 / 732074 (Daytime) and 01463 732081 (6.00pm-8.00am)

Guidance Notes

Taken from a joint statement from the BMA, the RC(UK) and the RCN February 2001

Presumption in favour of attempting resuscitation.

Where no explicit advance decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient suffering cardiac or respiratory arrest, and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to attempt to revive the patient. Anyone attempting CPR in such circumstances should be supported by their senior medical and nursing colleagues. Although this is the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of illness or for whom the burdens of the treatment clearly outweigh the potential benefits.

Essential aspects of decision making

Each case involves an individual patient with his or her own particular circumstances and it is important to ensure that these circumstances are central to each decision rather than applying the same decision to whole categories of patients. Ideally decisions about whether to attempt to resuscitate a particular patient are made in advance as part of overall care planning for that patient and, as such, are discussed with the patient along with other aspects of future care. An advance decision that CPR will not be attempted (a “do not attempt resuscitation”, or “DNAR” order) should be made only after the appropriate consultation and consideration of all relevant aspects of the patient’s condition. These include:

- the likely clinical outcome, including the likelihood of successfully restarting the patient’s heart and breathing, and the overall benefit achieved from a successful resuscitation;
- the patient’s known, or ascertainable, wishes; and
- the patient’s human rights, including the right to life and the right to be free from degrading treatment

The views of all members of the medical and nursing team, including those involved in the patient’s primary and secondary care and, with due regard to patient confidentiality, people close to the patient, are valuable in forming the decision. Once made, all decisions must be communicated effectively to the relevant health professionals.

Responsibility for decision making

The overall responsibility for decisions about CPR and DNAR orders rests with the consultant or GP in charge of the patient’s care. He or she should be prepared always to discuss the decision for an individual patient with other health professionals involved in the patient’s care, including, in the consultant’s case, the patient’s GP. The importance of team work and good communication cannot be over-emphasised.

Where care is shared, for example between hospital and general practice, or between general practice and a residential facility, the doctors involved should discuss the issue with each other, with other members of the health care team and with the patient and people close to the patient as appropriate. While responsibility for achieving agreement is a shared task, one individual should take charge of ensuring that the decision is properly recorded and conveyed to all those who need to know it, including locum staff.

Recording and communicating decisions

Any decision about the provision of attempted CPR must be readily accessible to all health professionals who may need to know it, including hospital staff, GPs, deputising or GP co-operative services, and ambulance staff for patients in the community. The patient’s known wishes, and decisions relating to attempting CPR should be communicated between health professionals when a patient is referred or discharged.

The entry in the medical records should clearly document and date the decision and the reasons for it, and should be made by the most senior member of the team available. This person should ensure that the decision is communicated effectively to other relevant health professionals in both primary and secondary care. In hospital, the consultant in charge of care will usually lead this process and may delegate the task of disseminating information to another member of the health care team. Where the GP takes the professional lead, he or she has responsibility for these tasks.

The decision should be recorded in the nursing notes by the primary nurse or the most senior member of the nursing team whose responsibility it is to inform other members of the nursing team.

Local protocols for information-sharing between health professionals may facilitate communication. Detailed guidance is not provided here since appropriate mechanisms will depend on the type of facilities involved and existing local protocols for communication.

Communication of decisions to the patient and people close to the patient is also a part of this process. Patients who want to be involved in decision making will be aware what decision has been reached and should be told how this will be communicated to the health care team. Health professionals should remember that patients are legally entitled to see and have a copy of their health records. Unless the patient refuses, decisions should also be communicated to the patient’s family and others close to the patient. The usual rules of confidentiality apply.

HOSPITAL CARDIOPULMONARY

RESUSCITATION POLICY

Revised January 2003

INTRODUCTION

This Policy endorses, and has been developed in accordance with guidance laid down by the Chief Medical Officer, the Joint Statement of the Resuscitation Council (UK), The British Medical Association and the Royal College of Nursing (June 1999).

In keeping with this position statement, all clinical staff employed, or contracted by NHS Highland will commence Cardiopulmonary Resuscitation on any individual entrusted into their care, where, cardiac or respiratory function ceases, unless specific circumstances have led the Consultant or General Practitioner in charge of the patient's care to institute a "Do Not Attempt Resuscitation" Order; a decision which is taken in line with the key principles detailed below.

Any such order must be clearly recorded in the patient's medical case notes by the Responsible Medical Officer. This decision must be shared with all members of the care team.

AIMS OF POLICY

- To clarify the individual roles and responsibilities of relevant clinical staff

- To provide a baseline operational framework for all NHS Highland staff in hospital

KEY PRINCIPLES

- Cardiopulmonary Resuscitation **will be attempted on any individual** where cardiac or respiratory arrest has occurred, unless the Consultant or General Practitioner in charge of the individuals care has instituted a **Do Not Attempt Resuscitate (DNAR)** order, which must be clearly recorded in the medical notes, along with the rationale for this decision and a review date.

- A Do Not Attempt Resuscitation decision applies solely to Cardiopulmonary Resuscitation. All other treatment and care appropriate for the individual will continue.

- Sensitive exploration of the individuals wishes regarding any potential resuscitation attempt should be undertaken when possible as well as identification of others whom the individual may wish to be involved in the discussion where DNAR is under consideration.

- Basic Life Support Training (Adult and Paediatric) will be available for all clinical staff and carried out by either the Resuscitation Officer or an identified key trainer.

- Immediate and Advanced Life Support training is available to appropriate nursing, medical and dental staff and provided by the Resuscitation Training Officer or a designated other.

- The Resuscitation Policy will be accessible to all staff. New members of staff will be informed of the policy and made familiar with relevant resuscitation equipment during their induction period.

• The resuscitation policy will be made available to all clients on request

• A Patient Information Leaflet is available relating to Cardiopulmonary Resuscitation

• Appropriate equipment will be available to staff to enable them to respond to a medical emergency within their scope of practice.

GUIDELINES FOR DO NOT RESUSCITATE ORDERS

It is appropriate to consider a Do Not Attempt Resuscitation decision in the following circumstances: -

• Where the patient's condition indicates that effective CPR is unlikely to be successful.

• Where Cardiopulmonary Resuscitation is not in accord with the recorded, sustained wishes of the patient who is able to make this informed decision.

• Where Cardiopulmonary Resuscitation is not in accord with a valid applicable advance directive, a patient's informed and competently made refusal, which relates to the circumstances, which have arisen, is legally binding upon staff.

• Where successful Cardiopulmonary resuscitation would likely be followed by a length and quality of life, which would not be in the best interests of the patient to sustain.

Responsibility for Cardiopulmonary Resuscitation decisions for in-patients rests with the medical practitioner in charge of the patient's care. It is essential that due consideration be given to the perspectives of other members of the medical and nursing team involved in the patient's care, as well as the patient themselves and, with due regard to confidentiality, where appropriate, relatives and close friends who should aim to reflect to wishes of the patient

RECORDING "DO NOT ATTEMPT RESUSCITATION" ORDERS

• Where a Do Not Attempt Resuscitation order is made the doctor must record this decision, **along with the rationale** in the medical notes ensuring the entry is signed and dated. It is the responsibility of the doctor to ensure that senior nursing colleagues are aware of the decision. It is essential that all relevant clinical staff be made fully aware of a DNAR order.

• The primary nurse or the most senior member of the nursing team should record resuscitation decisions in the nursing notes and ensure all members of the nursing team are informed of the decision.

• The senior PAM's staff member should ensure that all-appropriate members of their professional team are informed of resuscitation decisions and that this is recorded in the care plan.

All DNAR orders will be subject to regular review where changes in the patient's condition dictates. The responsibility for arranging and ensuring such reviews take place rests with the senior medical officer in charge of the patient's care.

PATIENTS' RIGHTS RELATING TO DNAR ORDERS

Adult Competent Patients
The patient has the ethical and legal right to be involved in all decisions that relate to them. They also have the right to access information about decision making in relation to CPR. The patient also has the right to refuse any medical treatment.

Incapacitated Adult Patients
Where a proxy decision maker has been appointed by a patient over the age of 16, this person has the legal right to give consent for treatment and should be consulted about treatment decisions where practicable. The views of the patient's nearest relative or carer should also be taken into account.

Children and young people
The views of children and young people must be taken into account in decisions relating to CPR. If a competent young person refuses treatment, or requests a DNAR order, it is likely that neither parents or the courts are entitled to override this decision.

Relatives/Carers
If the patient is competent, the relative/carer's views have no legal status in terms of actual decision making. The competent patient should also consent to others' views being sought. Where the patient is incapacitated, the relative/carer's input should be sought as it may be helpful in clarifying the patients' views.

STAFF TRAINING

Basic Life Support training will be available for all clinical staff. Training review will be undertaken regularly.

Immediate and Advanced Life Support training will be provided for appropriate clinical staff.

Information relating to the following Resuscitation Council (UK) and BASICS (Scotland) courses is available from the Resuscitation Officer:
Immediate Life Support
Advanced Cardiac Life Support
Paediatric Advanced Life Support
Advanced Trauma Life Support
BASICS part 1 & 2

ROLE OF THE RESUSCITATION TRAINING OFFICER

Facilitate and implement resuscitation training throughout NHS Highland using key trainers (nursing and PAMs staff) to train colleagues in Basic Life Support (BLS), defibrillation and anaphylaxis.

Providing Immediate Life Support courses, paediatric BLS and advanced life support training where appropriate on a NHS Highland wide basis

To train, support and assess all key trainers to ensure a consistent standard of training according to Resuscitation Council (UK) guidelines is being delivered

To maintain a NHS Highland wide database of all resuscitation training undertaken

To facilitate audit of resuscitation attempts using the universal Unstein tool to provide data of all medical emergencies requiring CPR and to establish any training requirements highlighted during this process

To provide training on request to GPs in the use of emergency equipment available in hospital or in emergency kits

To ensure adequate and appropriate resuscitation equipment is available in clinical locations and training is available in its use

To communicate with Team Leaders, local managers, Clinical Directorate and GPs to deal with any resuscitation issues and ensure the availability of training in all localities

Role of Key Trainers for Resuscitation

All hospitals/wards have an identified Key Trainers for resuscitation**.**

The Key Trainer provides basic life support and where appropriate, defibrillation and anaphylaxis training for all clinical staff in their area/team.

The key worker advises the RTO of all staff training undertaken in their area.

Key Trainers undertake the Immediate Life Support course on an annual basis

EQUIPMENT

All clinical areas will have appropriate resuscitation equipment available (see Appendix A).

It is beneficial to have an identified individual who will take responsibility for ensuring regular maintenance or replacement of any emergency equipment.

The RTO advises individual areas on all aspects of medical emergency equipment and ensures training in the use of such equipment is made available to staff.

AUDIT

Audit will be carried out in the following areas:

• Use of “Do Not Resuscitate” orders – completed June 2002

• Training delivered to staff

• Outcomes of attempted resuscitation using the Utstein style audit tool – ongoing

PATIENT INVOLVEMENT AND COMMUNICATION

Whilst it is acknowledged that communication between the patient, clinical staff and, where appropriate, relatives on the subject of resuscitation status is potentially difficult, patients have the right to have their views taken into account and respected in the decision making process. They also have the right to know if a DNAR order has been decided on for them.

Patients' rights should be respected at all times and will be central to the decision making process.

To supplement the sensitive communication which will take place between the medical/nursing staff, the patient and their relatives (or close friends) a patient information leaflet is available with information relating to CPR. This is not intended to replace one-one communications but may be an aide to further dialogue.

All wards will have a clearly identified strategy for informing all team members of current do not resuscitate decisions.

References

Scottish Executive NHS HDL (2000)22 Resuscitation Policy

"Decisions Relating to Cardiopulmonary Resuscitation" - A Joint Statement from the British Medical Association the Resuscitation Council (UK) and the Royal College of Nursing June 1998

Highland Primary Care NHS Trust Resuscitation Strategy May 2001

Pam Gowie
Resuscitation Officer
NHS Highland

CERTIFICATE OF INCAPACITY UNDER SECTION 47 OF THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

I _____(name)

of _____

_____(address)

being the medical practitioner primarily responsible for the medical treatment of

_____(name)

of _____

_____(address)

_____(date of birth)

for whom the guardian/welfare attorney/person appointed by intervention order/nearest relative/ carer is _____

have today examined the patient named above. I am of the opinion that he/she is incapable in terms of the Adults with Incapacity (Scotland) Act 2000 ("the Act") because of

_____(nature of incapacity)

in relation to a decision about the following medical treatment _____

_____

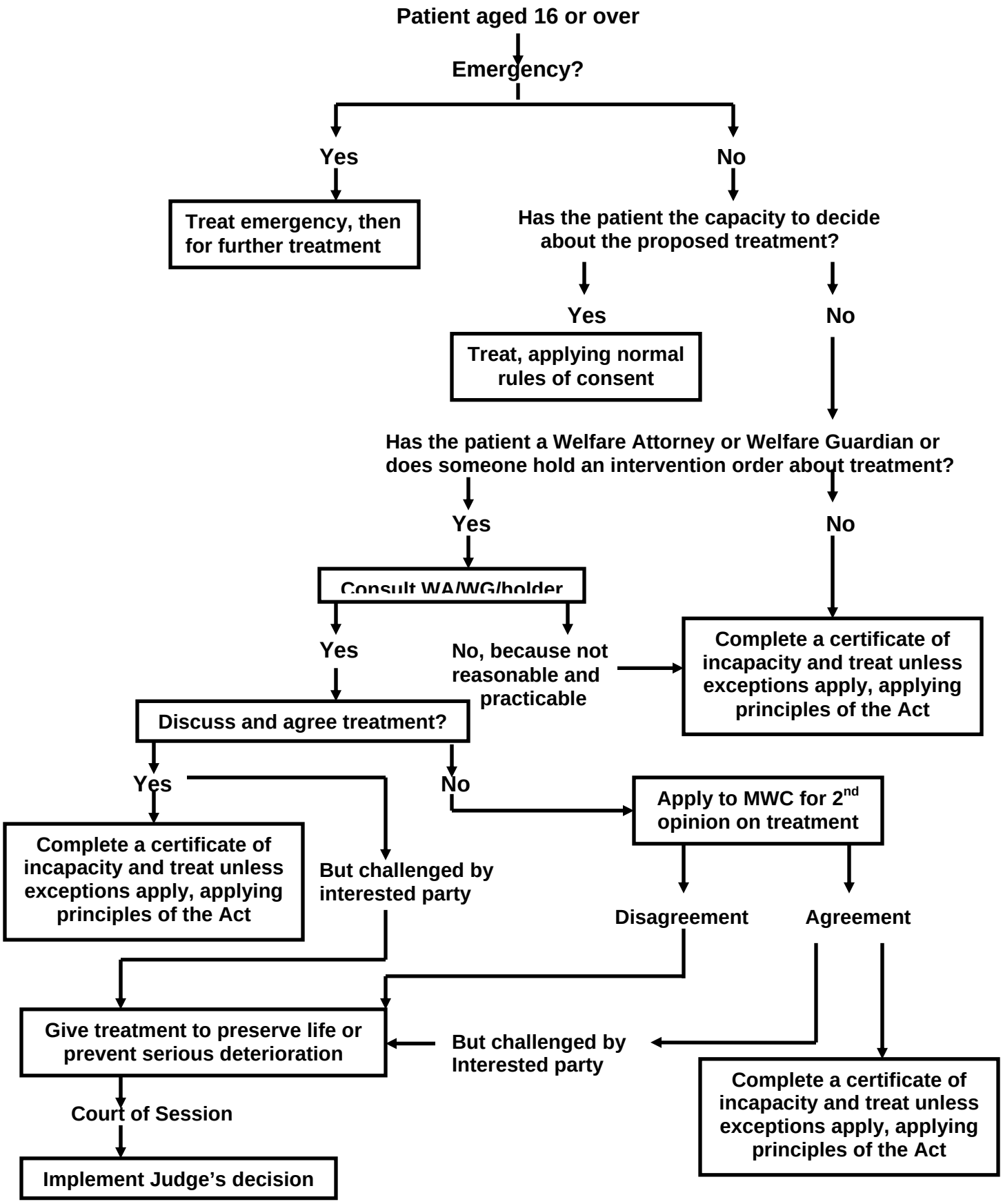
_____

This incapacity is likely to continue for _____ months. I therefore consider it appropriate for medical treatment to be authorized by this certificate until _____ (a date not more than one year later than the date of examination on which this certificate is base) or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient I have observed the principles set out in section 1 of the Act.

Signed _____ (Date) _____/_____/_____

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000
PART 5 – MEDICAL TREATMENT – FLOWCHART



SCHEDULE 1

Regulation 2

CERTIFICATE UNDER SECTIONS 15(3)(c) AND/OR 16(3)(c) OF THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000 TO BE INCORPORATED IN A DOCUMENT GRANTING A POWER OF ATTORNEY

1. This certificate is incorporated in the document subscribed by

Insert name of granter

2. On

Insert date subscribed

3. That confers a

Tick appropriate box – tick one box only

- ☐ • Continuing power of attorney (i.e. confers property or financial powers only)
- ☐ • Welfare power of attorney (i.e. confers welfare powers only)
- ☐ • Combined power of attorney (i.e. confers both property or financial and welfare powers)

4. Appointing as Attorney(s)

Insert name(s) of Attorney(s)

5. Declaration of Certifier

Note: any person signing this certificate should not be the person to whom this power of attorney has been granted.

I certify that

1. I interviewed the granter ***immediately*** before he/she subscribed this power of attorney;

2. I am satisfied that, at the time this power of attorney was granted, the granter understood its nature and extent; and

   I have satisfied myself of this:
   Please tick appropriate box. (Both may apply but one must apply)

   ☐ (a) because of my own knowledge of the granter;

   and/or

   ☐ (b) because I have consulted the following person who has knowledge of the granter on the matter

   Insert name, address and relationship with granter, of person consulted

3. I have no reason to believe the granter was acting under undue influence or that any other factor vitiates the granting of this power of attorney.

Signed: .....

Print name: .....

Profession: .....

Address: .....

.....

.....

Date: .....

POWER OF ATTORNEY DOCUMENT	✓
Power of Attorney is signed by granter	
Incorporates a statement clearly expressing granter's intention that the power is continuing and/or welfare	
Where welfare powers are granted – a statement is incorporated stating the granter has considered how their incapacity will be determined	
Where financial powers are granted that are to start only on the granter's incapacity - a statement is incorporated stating the granter has considered how their incapacity will be determined	
If copies are to be sent to specified individuals, this is stated within the document	
Nothing in the document prevents registration (no springing clause)	
If power of attorney revokes previous powers of attorney, a certificate in terms of SSI 56/2008 Schedule 2 is enclosed.	
PRESCRIBED CERTIFICATE	✓
Certificate is in prescribed form (SSI 56/2008) Schedule 1. N.B. *If conferring welfare and financial powers, a single certificate may be incorporated.*	
Granter's name is entered and matches name on document	
Date granter subscribed the power of attorney document is entered on certificate	
Attorney(s) name(s) entered and this matches name(s) on document	
At least 1 box ticked at section 5(2). Either (a) or (b) or both	
Where appropriate, details of anyone else consulted is entered at (b). N.B. *It is preferred that the nominated attorney is not the person consulted due to the potential conflict of interest*	
Certificate signed by a practising Scottish solicitor, medical practitioner or legal advocate	
Certifier details completed in full	
Certifier is not the person granted power of attorney	
REGISTRATION FORM	✓
Registration form is completed	
Attorney(s) have signed confirming they are willing to act.	
REGISTRATION FEE	✓
Correct fee enclosed – refer to OPG website	
Cheque made out to 'The Scottish Court Service'	
NB: Failure to submit a valid document will lead to its rejection.	

Useful Website Addresses for Further Information

Citizens Advice Bureau: www.cas.org.uk

Office of the Public Guardian: www.publicguardian-scotland.gov.uk

Scottish Helpline for Older People: www.olderpeoplescotland.co.uk

Age Concern Scotland: www.ageconcernandhelptheagedscotland.org.uk

Guide for Accessing GP Portal Site and SPARRA Data

1. Go to the NHS Highland Intranet Homepage or follow the attached link http://intranet.nhsh.scot.nhs.uk/Pages/Default.aspx

2. Click on 'Organisation' (fourth tab from the left at the top of the page)

3. Click on 'GP Practices' Under 'Partner Organisations' (last list on the right)

4. Click on the relevant Practice (listed by CHP)

5. Sign in to access Secure Data in the GP Practice Portal (Sign in button in top right hand corner of page)

6. Once signed in, you should be able to see 3 options on the left hand side of your screen (Secure Patient Data, Secure Practice Area, Exchange Area)

7. Click on 'Secure Patient Data' on the left hand side of the screen.

8. Click on the attachment under 'Casefinder Data' to access the SPARRA Data for your Practice.

Please note: Only staff that have completed an AR1 form will be able to access the Secure Patient Data sub site of the GP Portal.