UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION FORM

DNACPR valid across all adult care settings in Bristol, N Somerset and S Gloucester PCTs

In the event of cardiac or respiratory arrest, no attempts at CPR will be made.
All other appropriate treatment and care will be provided.

NHS Bristol North Somerset South Gloucestershire

Name
Address

Postcode
Date of birth
NHS number

Before completing form, see explanatory notes overleaf.

Date of DNACPR decision: __ / __ / ____

Record the full extent of discussions in the notes

1. Reason for DNACPR decision (tick A,B or C):

☐ **A) CPR is unlikely to be successful due to**.....
.....
.....

This has been explained to the patient Yes ☐ No ☐
Reason why not.....
This has been explained to the relevant other Yes ☐ No ☐ Name .....

☐ **B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the patient.**

- Patient involved in discussions? Yes ☐ No ☐
- If no, state reason: .....
- Patient lacks mental capacity and a best interests decision has been made after consulting with
  - their legally appointed Welfare Attorney: Name .....
  - the patient's representative (eg relative or IMCA): Name .....

☐ **C) DNACPR is in accord with the sustained wishes of the patient.**

- Patient has capacity and does not want to be for CPR. (Record full extent of discussion in notes) Yes ☐ No ☐
  OR
- Patient lacks capacity; a valid and applicable Advance Decision to Refuse Treatment has been seen. Yes ☐ No ☐

2. Healthcare professional making this DNACPR decision:

Name Position
Signature Date / / Time :

Healthcare professional verifying if original decision made by a professional without overall responsibility for the patient:
Name Position
Signature Date / / Time :

3. Review:

☐ **This is an indefinite decision**
☐ **This needs review if clinical situation changes**

Review date if appropriate / / Outcome of review: DNACPR to continue? Yes ☐ No ☐
Name Position
Signature Date / / Time :

4. Who has been informed of this DNACPR decision?

Please inform all relevant parties and tick when informed:

☐ GP ☐ Out of Hours ☐ Other care provider (please state)

☐ **Fax this form to the ambulance service on 08451 204340 or email to SWASNT.clinical-alerts@nhs.net**

5. Other important information:

For example, ambulance crew instructions, Advance Care Plans such as preferred place of care/death, ceilings of treatment.

.....
.....
.....

Red-bordered original form to travel with the patient. Photocopy of form to be kept in medical notes.

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FORM

This form has been approved for use across all care settings in Bristol, N Somerset and S Gloucester (BNSSG) PCTs.

Guidance for completion:

- This form should be completed legibly in black ink.
- The patient's full name, NHS or Hospital number, date of birth, address and date of decision should be written clearly.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines and "CANCELLED" written clearly between them, signed and dated by the healthcare professional.
- It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4 on form).

The original form should remain with the patient, but keep a copy in the patient's notes for audit purposes.

1.	Reason for DNACPR decision	
1A	CPR is unlikely to be successful	• Summarise the main clinical problems and reasons why CPR would be unsuccessful**.** Be as specific as possible. • Explain the decision to the patient (and relatives/carers if the patient lacks capacity) and ensure that they are aware of their current condition. • Record the details of discussion or the reason for not discussing in the patient's notes.
1B	CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the patient	State clearly what was discussed and agreed. **If the patient has capacity**, they should be involved in discussions. State the names and relationships of relatives / relevant others with whom this decision has also been discussed. Ensure that discussion with others does not breach confidentiality. Details of discussions should be recorded in the clinical notes. **If the patient does not have capacity**, but has a valid and applicable Advance Decision to Refuse Treatment (ADRT), it must be respected. If the patient has a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. If there is no ADRT or LPA, the decision should be made in the best interests of the patient after consulting with their relatives / friends as to what the patient's wishes might have been. Those close to the patient should not be asked to make the decision. If there is no one appropriate to consult and the patient lacks capacity then an instruction to an Independent Mental Capacity Advocate must be made. All decision-making should be in keeping with the Mental Capacity Act 2005.
1C	DNACPR is in accord with the sustained wishes of the patient.	Record the assessment of capacity in the clinical notes. If the patient has capacity, they may state that they do not want CPR in the event of a cardiopulmonary arrest. If they lack capacity, any Advanced Decision to Refuse Treatment must be valid and applicable for the patient's current circumstances.
2.	Healthcare professional making this DNACPR decision/ verification	State name and position. This should be the most senior healthcare professional immediately available. The decision must be verified by the most senior healthcare professional responsible for the patient's care at the earliest opportunity (within 48 hours in Acute Trusts). If the person making the decision is the most senior person, verification is not required.
3.	Review	State whether the decision is indefinite or needs review. It should be reviewed if: i) there are changes in the patient's condition ii) the patient's expressed wishes change and CPR is likely to be successful Reviewer needs to complete all details on the form and document the outcome in the notes.
4.	Who has been informed of this DNACPR decision?	Ensure that all healthcare professionals who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the patient. Fax the form to the ambulance service and the GP practice.
5.	Other information	Prior to ambulance transfer, document any instructions for transfer such as name, address, telephone number of destination and next of kin. Document any known patient's wishes / Advance Care Plans such as preferred place of care etc.

Care Plan

TREATMENT ESCALATION PERSONALISED PLAN

University Hospitals Bristol NHS
NHS Foundation Trust

Setting:	Trustwide
Patients:	Adults
For use by:	Medical staff for use with patients identified as not for full escalation of treatment. File at the front of the notes.

Hospital no: .....

NHS no: .....

Surname: .....

Forename: .....

Gender: ..... D.o.B: .....

The decision has been made that the patient is not for full escalation of treatment. Where possible, treatment decisions should be informed by discussion with the patient, their relatives and the multidisciplinary team and documented in the medical notes. **Review all treatment decisions as the patient's clinical condition changes and on senior reviews. This form is valid for this admission only.**

DECISION MAKING: (please circle)

- Does the patient have a Do Not Attempt Cardio-Pulmonary Resuscitation form? Yes No
- Does the patient have a valid Advance Decision to Refuse Treatment (ADRT)? Yes No
- Would the following interventions be **medically** appropriate?

Intravenous antibiotics	Yes	No
Ward non-invasive ventilation	Yes	No
Referral to intensive care	Yes	No
Artificial feeding	Yes	No

- Is patient thought to be in the last days of life (consider the end-of-life tool) Yes No

Document rationale for treatment decisions (be as specific as possible):

.....

.....

.....

.....

.....

COMMUNICATION:

- Is the **patient** aware of their Treatment Escalation Personalised Plan (TEPP)? Yes No
  If no, reason why not: .....

- If the patient lacks capacity, are the **relatives** aware of the plan? Yes No
  If no, reason why not: .....
  Name of person involved in discussions: .....
  Relationship to patient: .....

Signature of doctor completing the form: ..... Date: .....

Print name: ..... Grade of doctor: .....

If written by a junior doctor, name of Consultant involved in decision making: .....

Verified by consultant: ..... Date:.....

REVIEW AT LEAST WEEKLY:

Review date:	Outcome eg remains valid, cancel, new TEPP	Signature / print name	Grade of doctor

University Hospitals Bristol NHS
NHS Foundation Trust

SYMPTOM OBSERVATION CHART

Setting: Trustwide
Patients: Adults, when standard EWS observation chart is no longer appropriate as decided by the multidisciplinary team
For use by: Nurses

Hospital no: _____
NHS no: _____
Surname _____
Forename _____
Gender _____ D.o.B. ___/___/_____

To be completed every **4 hours** if any symptom is mild or none.
To be completed every **1 hour** if any symptom is severe or moderate.

Date																				
Time																				
Initials																				

PAIN

9 - 10																				
7 - 8																				
5 - 6																				
3 - 4																				
1 - 2																				
0																				

NAUSEA & VOMITING

Severe																				
Moderate																				
Mild / None																				

AGITATION

Severe																				
Moderate																				
Mild / None																				

RESPIRATORY SECRETIONS

Severe																				
Moderate																				
Mild / None																				

SHORTNESS OF BREATH

Distressing																				
Not Distressing																				

MOUTH CLEAN & MOIST / OFFER SIPS OF FLUID IF ABLE TO SWALLOW SAFELY

No																				
Yes																				

SEVERE SYMPTOMS (ACT)

- Look for reversible causes
- Consider non-pharmacological treatment e.g. positioning
- Give medication for symptom
- Regular review until symptom control is achieved

MODERATE SYMPTOMS (ACT)

- Look for reversible causes
- Consider non-pharmacological treatment
- Give medication and review until symptom control is achieved

MILD OR NO SYMPTOMS

- No intervention required

ACTION REPORT FOR:
Symptom score ≥ 3 (or moderate or severe)
Reassess within 1 hour

Date	Time	Comment	Action taken and Outcome	Initials

SYMPTOM SCORE:

If score 0 – 2 . . . . then 4 hourly observations
If score ≥ 3 . . . . then 1 hourly observations and inform nurse in charge

Complete action report above

UBHT1168

Care Tool

UHBRISTOL END OF LIFE CARE TOOL - NURSING

Setting: Trustwide
Patients: Adults
For use by: Nurses

CAUTION - Do not use away from this specified scope

Hospital no: _____
NHS no: _____
Surname _____
Forename _____
Gender _____ D.o.B. ___/___/_____

The multidisciplinary team has agreed the patient is dying. Reversible causes of deterioration have been considered and the patient is deteriorating despite optimal medical management. No further active interventions are considered appropriate. This tool aims to help the multidisciplinary team provide the best possible care for patients and their families at the end of life; all usual medical documentation should continue in the medical notes.

INITIAL NURSING ASSESSMENT

Discuss patient's condition with the medical staff	Yes ◯	No ◯	
Stop unnecessary observations (Continue care rounding)	Yes ◯	No ◯	
Start symptom assessment chart	Yes ◯	No ◯	
Is pressure relieving mattress needed?	Yes ◯	No ◯	
Is catheterisation appropriate?	Yes ◯	No ◯	
Assess religious / spiritual needs			
with patient	Yes ◯	No ◯	n/a ◯
with family	Yes ◯	No ◯	n/a ◯
religious or spiritual needs identified	Yes ◯	No ◯	n/a ◯
chaplaincy support offered	Yes ◯	No ◯	n/a ◯
Assess emotional / psychological needs			
with patient	Yes ◯	No ◯	n/a ◯
with family	Yes ◯	No ◯	n/a ◯
support offered	Yes ◯	No ◯	n/a ◯
Discuss tissue / organ donation	Yes ◯	No ◯	n/a ◯
Identify how family are to be informed of patient's impending death	Yes ◯	No ◯	n/a ◯
Give family relevant hospital information (e.g. unrestricted visiting)	Yes ◯	No ◯	n/a ◯
Update key primary care professionals (e.g. GP surgery, district nurse)	Yes ◯	No ◯	n/a ◯

Completed by: Print name: ..... Sign: ..... Role: ..... Date: .....

ONGOING CARE

- Complete symptom assessment chart and ask doctors to change medications accordingly
- Regular mouth care and offer sips of fluid if patient can swallow safely
- Ask patient and family if they have any questions

If you have any concerns or questions, please contact the Specialist Palliative Care Team by referring the patient on ICE, or for telephone advice ring [redacted] or bleep via switch.

CARE AFTER DEATH

Procedures for 'last offices' following hospital policy	Yes ◯	No ◯
Complete 'Following the Death of a Patient' checklist	Yes ◯	No ◯

Completed by: Print name: ..... Sign: ..... Role: ..... Date: .....

UBHT1170

Guideline for Anticipatory Prescribing at the End of Life May 2015				
When a patient is recognised as dying by the team caring for them, it is important to prescribe 'as required' (PRN) subcutaneous (SC) medication for the common symptoms that can occur at the end of life as the patient will be unable to take oral medication. **Not** all patients will need a syringe driver, but should at least have these PRN drugs prescribed.				
Anticipatory prescribing guidance: Prescribe at least one PRN drug for each symptom				
Symptom	**Drug**	**PRN dose (SC)**	**Usual starting dose in syringe driver (if needed) over 24 hours (SC)**	**Range in syringe driver over 24 hours (SC)**
Pain	**Usual opioid**	1/6 of 24hr SC dose	Convert from oral opioid	No upper limit
	OR, if opioid naive: Morphine if eGFR<30ml/min **OR** Fentanyl if eGFR<30ml/min	2.5-5mg 1 hourly prn 25-50 micrograms fentanyl	Use prn only for 24hrs to establish opioid requirements	
Nausea				
Opioid / centrally induced	Haloperidol †	1.5-3mg bd	3-5mg	3-10mg
	and / or Cyclizine *	50mg tds	150mg	100-150mg
Prokinetic	Metoclopramide †	10mg tds	30mg	30-80mg
Second line	Levomepromazine †	6.25mg tds	6.25mg	6.25-25mg
Respiratory tract secretions	Hyoscine butylbromide *	20mg 2 hourly PRN	60mg	60-240mg
Agitation *+ confusion*	Haloperidol †	1.5-3mg bd	3-10mg	3-10mg
+ anxiety	Midazolam	2.5-5mg 1 hourly	10-30mg	10-90mg
OR 2nd line	Levomepromazine †	12.5-25mg tds	12.5-50mg	12.5-200mg
Breathlessness	Morphine / fentanyl	See pain doses	See pain guidance	See pain doses
	Midazolam for panic	2.5-5mg 1 hourly	10mg	10-90mg

† Caution in Parkinson's disease.

*Cyclizine and hyoscine butylbromide (Buscopan) are incompatible when mixed in a syringe driver

University Hospitals Bristol NHS
NHS Foundation Trust

Care Tool

UHBRISTOL END OF LIFE CARE TOOL - MEDICAL

Setting: Trustwide
Patients: Adults
For use by: Doctors

CAUTION - Do not use away from this specified scope

Hospital no: _____
NHS no: _____
Surname _____
Forename _____
Gender _____ D.o.B. ___/___/_____

The multidisciplinary team has agreed the patient is dying. Reversible causes of deterioration have been considered and the patient is deteriorating despite optimal medical management. No further active interventions are considered appropriate. This tool aims to help the multidisciplinary team provide the best possible care for patients and their families at the end of life; all usual medical documentation should continue in the medical notes.

INITIAL MEDICAL ASSESSMENT

Discuss current situation with the patient	aware of diagnosis	Yes ◯	No ◯	↓ conscious level ◯
	recognition of dying	Yes ◯	No ◯	↓ conscious level ◯
	nutrition and hydration	Yes ◯	No ◯	↓ conscious level ◯
Discuss current situation with the family	aware of diagnosis	Yes ◯	No ◯	
	recognition of dying	Yes ◯	No ◯	
	nutrition and hydration	Yes ◯	No ◯	

Assess symptoms – which are present? (and see symptom observation chart)

pain	Yes ◯	No ◯	nausea and vomiting	Yes ◯ No ◯
agitation	Yes ◯	No ◯	respiratory secretions	Yes ◯ No ◯
breathlessness	Yes ◯	No ◯	urinary problems	Yes ◯ No ◯
dry mouth	Yes ◯	No ◯	constipation/diarrhoea	Yes ◯ No ◯

Consider converting appropriate oral medications to a syringe driver	analgesics	Yes ◯	No ◯	n/a ◯
	antiemetics	Yes ◯	No ◯	n/a ◯
	anxiolytics	Yes ◯	No ◯	n/a ◯
	other (antiepileptics)	Yes ◯	No ◯	n/a ◯
Write up PRN medications for (see drugs overleaf)	pain	Yes ◯	No ◯	
	nausea and vomiting	Yes ◯	No ◯	
	agitation	Yes ◯	No ◯	
	breathlessness	Yes ◯	No ◯	
	respiratory secretions	Yes ◯	No ◯	
Stop unnecessary interventions	blood tests	Yes ◯	No ◯	n/a ◯
	IV fluids	Yes ◯	No ◯	n/a ◯
	IV antibiotics	Yes ◯	No ◯	n/a ◯
Stop unnecessary observations		Yes ◯	No ◯	
Stop non-essential medications		Yes ◯	No ◯	
Complete DNACPR form		Yes ◯	No ◯	
Discuss preferred place of care		Yes ◯	No ◯	
Implantable Cardioverter Defibrillator deactivated? (See guidance on DMS)		Yes ◯	No ◯	n/a ◯
Discuss tissue / organ donation (See guidance on DMS)		Yes ◯	No ◯	n/a ◯
Inform GP of situation		Yes ◯	No ◯	

Completed by: Print name: ..... Sign: ..... Role: ..... Date: .....

ONGOING CARE

Continue assessment of symptoms and change medications accordingly. Ask patient and family if they have any questions.
If you have any concerns or questions, please contact the Specialist Palliative Care Team by referring the patient on ICE, or for telephone advice ring [redacted] or bleep via switch.

Guideline for Anticipatory Prescribing at the End of Life May 2015				
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