

Let's think ahead



# Guidance for health and care professionals

## Anticipatory Care Planning



**This guidance has been developed to help health and care professionals to support individuals who would benefit from Anticipatory Care Planning.**

**A number of Anticipatory Care Planning documents have been developed for use across Scotland. People may also choose to use the My Anticipatory Care Plan “Let's think ahead” App that is available for download free of charge from the App Store.**

**More information is available at [myacp.scot](http://myacp.scot).**

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## Background

Anticipatory Care Planning (ACP) is a person-centred, proactive, “thinking ahead” approach, requiring services and health and care professionals to work with individuals, carers and their families to have the right conversations and set personal goals to ensure that the right thing is done at the right time by the right person with the right outcome.

In Scotland, ACP has largely been considered as important when the person’s needs become more complex but it can be started at any stage of that person’s care.

ACP is about understanding the individual’s situation and their health conditions. It is about helping people to navigate the system and make informed choices about their care and place of care. It requires a supportive whole-system approach to improve quality of life and ensure delivery of positive outcomes.

An Anticipatory Care Plan is a dynamic record that should be developed over time through an evolving conversation, collaborative working and shared decision-making.

- It should be reviewed and updated as the individual's condition or personal circumstances change and different things take priority.
- It is a summary of the “thinking ahead” discussions between the person, those close to them and health and care professionals supporting them.
- It is a record of the preferred actions, interventions and responses that care providers should make following a deterioration in health or a crisis in the person's care or support.
- It should highlight the person's personal goals, preferences, views and concerns.

As care becomes more complex, it may be helpful to discuss legal and practical issues as well as care and support preferences. As the needs and dependency of the person increase, it may become appropriate to talk about care towards the end of life within these conversations.

ACP will include additional information about the person's:

- understanding about their illness and prognosis, and
- wishes and views about end of life care, including preferred place of care, as well as their views about any interventions, treatments and whether or not cardiopulmonary resuscitation is appropriate or wanted.

For ACP to work we need to build on existing good practice. This requires a cultural shift and change in the way we work to develop a robust community infrastructure that has the capacity and capability to provide 24/7 care, improve quality of life and manage more people more independently out of hospital.

Optimal outcomes and improving quality of life through ACP are helped by early intervention when people have complex needs or changing circumstances.

While the work responds to the challenge of providing care for an ageing population with increasing prevalence of long term conditions and multiple morbidities, ACP is relevant for all ages.

Health and care professionals should be aware that there is increasing evidence that appropriate access to community services and good anticipatory care, supported by the development of a Key Information Summary (KIS) that contains the right information, can reduce the risk of hospital admission by 30–50%.

## Considering the Anticipatory Care

### Planning process

It is estimated that 5-6% of the population have the complexity of need where they could potentially benefit from ACP. Individuals should be identified and offered interventions in a timely way to enable informed choice and ensure optimal outcomes.

Starting ACP can be prompted by a range of triggers. These can be thought of as a series of prompts for health and care professionals based on the individual's situation, condition and assessment.



## ACP triggers

<b>Situation:</b>
Frequent unscheduled contacts
Carer and family stress
Unplanned hospital admissions
Complex physical or mental health needs
Babies, children and young adults with complex or palliative care needs
Living in a care home
Receiving respite care
Long term housebound (all ages) or living alone
Recognised as vulnerable due to social or environmental circumstances
<b>Condition:</b>
Deteriorating long term condition or conditions
Frailty
Requiring specialist nurse or multidisciplinary team input
On certain disease registers, including palliative care, dementia, mental health, learning disability
<b>Assessment:</b>
Identified as vulnerable using risk predictive tools
Polypharmacy review
Falls assessment
Identified as vulnerable or unstable by professional or team

## Recognising health inequalities

It is important to recognise that ACP may be a factor in recognising and helping to reduce health inequalities.

Socio-economic disadvantage and inequalities are inter-related.

In the most affluent areas of Scotland, men live an average of 12.5 years longer than those in the most deprived areas (and women 8.5 years).

In deprived areas, on average, the number of years living with poor quality health is also significantly higher. Multimorbidity is also more common.

Health inequalities also exist between groups of people based on personal factors such as gender, sexuality, ethnicity, disability, homelessness or being a carer.

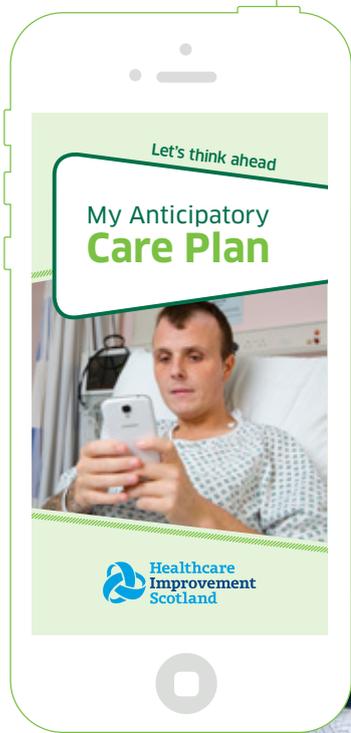
Discrimination and lack of awareness can result in poor health literacy and outcomes and cause barriers to accessing services, employment and education.

In addition to the guidance for health and care professionals, a number of other national documents have been developed to support ACP across Scotland:

- My Anticipatory Care Plan
- My Anticipatory Care Plan "Let's think ahead" App - available for download free of charge from the App Store
- Anticipatory Care Planning - What you need to know
- Anticipatory Care Planning - Things to think about

Let's think ahead →

# My Anticipatory Care Plan



Scottish Government  
Riaghaltas na h-Alba  
gov.scot

Let's think ahead →

## Anticipatory Care Planning What you need to know



Scottish Government  
Riaghaltas na h-Alba  
gov.scot

Let's think ahead →

## Anticipatory Care Planning Things to think about



Scottish Government  
Riaghaltas na h-Alba  
gov.scot

## Beginning the process

It is important for the individual (and the health and care professional) to understand that it is the person's Anticipatory Care Plan and they should have ownership of it.

Before developing an Anticipatory Care Plan supported by a health and care professional, it is important that the person understands its relevance so that the conversation can be placed in context. Individuals should be helped to understand that ACP is a voluntary process. The ACP documents belong to the individual and are not considered to be “legal” documents. Initial discussion should involve exploring their understanding of their conditions and prognosis.

All conversations should involve simple and clear language, with technical terminology avoided as much as possible. The person should be reassured that ACP is an opportunity to clarify their priorities and wishes for their future care and to plan accordingly. ACP encourages them to focus on what is important to them, to talk about the future if they wish (including death and dying) and to feel more in control of their future care.

The following points may help with this process:

- ask the person what they understand about their current situation and what they think might happen in the future. It is useful to know what they have been told by other health and care professionals and have learnt from other sources, like the Internet.
- ask about past experiences with illness, either their own or others.
- clarify concerns, expectations and fears about the future in relation to their health care.
- identify any gaps in their understanding by describing what ACP is and what the rationale is for having ACP conversations. They should be made aware that they are able to change their views and preferences at any time and make changes to their Anticipatory Care Plan as and when they wish.

People may need time for reflection and discussion after they have had an initial discussion about ACP.

ACP conversations should take place in an environment that:

- is non-threatening
- offers privacy, quietness, space and time for reflection, and
- is familiar to the person so that they feel comfortable.

Some people may wish to be accompanied or supported by someone close to them and others may prefer these discussions to take place privately. It is important to check this with the person.

## **Key Information Summary**

The Key Information Summary (KIS), currently hosted on the GP IT system, enables the development of an electronic Anticipatory Care Plan from the GP system. It can also be accessed across other services in acute and emergency care. The KIS contains information considered valuable to informing appropriate interventions. Ongoing work is focused on evolution of KIS to enable greater accessibility and cross-sector working.

If an Anticipatory Care Plan is developed, a KIS can be completed in the GP electronic record and contain ACP information and wishes. This can be shared with other healthcare settings with the person's consent.

## **Clinical management plan**

It might be appropriate for the professional supporting the individual to summarise important clinical details in the clinical management plan at the end of the Anticipatory Care Plan.

## Challenges of Anticipatory Care

### Planning and clinical practice

It is important to recognise that there are challenges to effective ACP in the health and social care sectors and wider community. These challenges may include:

- time constraints on health and care professionals which can influence their ability to initiate ACP conversations and may impact on the quality of any discussions because ACP requires preparation and planning by health and care professionals. It is important to recognise that discussions should take place in appropriate settings, with sufficient time to clarify a person's understanding and consider different options.
- the person, family or health and care professionals feeling uncomfortable talking about end of life issues or assuming that ACP is only about end of life care.
- lack of awareness of their right to participate actively in treatment decision-making or preferring their doctors to lead the medical decision-making may make people less inclined or less willing to engage in the ACP process.
- fear about being unable to change their minds once treatment preferences are documented. Therefore, it is always important to explain to the person that they have the right to change their mind about treatment preferences at any time. Health and care professionals play a crucial role in empowering the person to review and revise their Anticipatory Care Plan to ensure that their wishes remain current and up to date.
- lack of awareness about ACP and Advance Directives, or the medical implications of their documented preferences.

## End of life care

The term “end of life” can mean different things to different people; the focus is on preparation for the last few months, weeks, days and hours of life.

For a person, talking about death with the people closest to them is not easy, however it means that they will know what the person’s wishes are when the time comes, and helps them to look after the person in the way that the person would want.

It is well understood that not knowing exactly when to expect death can be one of the most difficult aspects of dying for individuals, their families and carers.

When a person is in the later stages of illness, it can be difficult to diagnose precisely when and how death will occur. A person’s condition can unexpectedly change for the better or worse at any time around this period. Often regular reviewing and noticing how things are changing over time is the only dependable or useful tool for assessment, with a focus on adequate symptom control and optimising quality of life for that person.

It is important to include the person who is dying and those close to them in discussion and decision-making as much as possible. More information is available at [www.ec4h.org.uk](http://www.ec4h.org.uk).

Health and care professionals should be sensitive to different cultural perspectives on illness, death and dying and on how end of life decisions are to be made, and by whom. It is important that they do not make any assumptions about the information needs of a person based on their cultural background; these needs should be clarified with the person directly.

## Limitations of treatment

People who live with long term, chronic medical conditions will often have periods of improvement and periods where the condition is worse. Over time, treatments often become less effective or less treatments are considered appropriate with a worsening condition and weakening state. In these situations, the person's professional team will often support the individual by discussing the limited benefits of treatment available, what is important now, and what can be done to help them.

## Resuscitation issues

Conversations with people and their families about resuscitation or to not attempt resuscitation should not be held in isolation, but should be sensitively facilitated within the wider context of ACP.

As far as possible, and at an appropriate stage, a proactive resuscitation or Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision should be communicated in a way that informs the actions of health professionals when an individual's pulse or breathing has stopped.

A consistent and instantly recognisable document is essential and the NHSScotland DNACPR form is recommended as best practice (see Appendix 1).

An advance DNACPR decision should also be shared using the Key Information Summary (KIS). DNACPR forms and decisions should be discussed with the individual (or their advocate or welfare attorney) whenever possible. They should also be shared as appropriate with other health and care professionals involved in the individual's care.

It is good practice to include and involve the person's family or close friends in these decisions.

If the clinical situation is such that a form is signed without discussion with the individual and family members and the patient's condition improves, the conversation must take place as soon as possible.

When a decision about CPR is discussed, made and recorded, clinicians should try to be clear about the basis for the decision. For example, it may be made with and/or for:

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 the first two of these CPR will not be successful and should not be offered or attempted. In the third and fourth, the wishes of the patient are paramount. In the context of an acute illness or acute exacerbation or relapse of a chronic condition, consideration of an anticipatory decision about CPR should prompt also consideration of what other supportive treatments or higher-level care may or may not be needed by, wanted by or appropriate for each individual patient. There should be early involvement of senior, experienced clinicians in decision-making in such situations.*

*Decisions relating to CPR – guidance from the BMA, RC(UK) and RCN 3rd ed (1st revision) 2016*

Limits of a patient's treatment should be included in all management plans for people with completed DNACPR forms.

Communication about DNACPR status can be achieved between teams by completing Anticipatory Care Plans for people with long term conditions, complex needs and frailty as well as those requiring end of life care.

For children and young people, the wider anticipatory care document contained within the Children/Young People Acute Deterioration Management (CYPADM) policy is more relevant and appropriate to use for communicating advance decisions on emergency treatment and care which includes cardiopulmonary resuscitation (CPR). However, it is acknowledged that there may be patients for whom use of the CYPADM remains appropriate well past their 18th birthday.

For children and young people with complex and palliative care needs, more detailed discussion can be helped by completing a CYPADM form (see Appendix 2).

It is not unusual for patients and their relevant others to have unrealistic expectations of the success of CPR and also its consequences. Where CPR is a treatment option, realistic and honest explanations about the expected outcomes in terms of survival to discharge should be included in discussions with patients and those close to them. This information is an essential part of informed, shared decision-making.

Consideration of the outcome of CPR should be as realistic as possible and should take into account the clinical condition and functional status of the patient, the likely cause of the anticipated arrest, and also the environment in which the patient is being cared for. Making this complex clinical judgement is a core responsibility of every experienced clinician.

More information about decisions relating to resuscitation can be found at [www.gov.scot/resource/0050/00504976.pdf](http://www.gov.scot/resource/0050/00504976.pdf).

## **Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)**

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a UK initiative to support ACP and the ACP process (see Appendix 3).

It is not planned to adopt ReSPECT immediately in Scotland, but a trial implementation of the ReSPECT process is now under way.

More information about ReSPECT can be found at [www.respectprocess.org.uk](http://www.respectprocess.org.uk).

## People requiring special considerations

Effective ACP depends on the person being able to communicate with health and care professionals and to make choices and decisions about their future care and treatment. Everything possible should be done to maximise the ability of the individual to participate in decision-making. Therefore, for some individuals and groups, ACP will present particular challenges and for others it may not be possible.

Where the individual has impaired competence or decision-making capacity, and/or where there are speech, language, learning or communication support needs, health and care professionals will need to carefully consider their approach to ACP. An independent advocate might be able to support a person with impaired capacity to articulate their views and wishes.

Everything possible should be done to maximise the ability of the individual to participate. Health and care professionals should make themselves aware of any supports that have been identified that will ensure best success, for example the use of written prompts, communication aids (hi or lo tech), supportive images and interpreter services. Liaison with other professionals, for example speech and language therapy, will help with this process. Tools and resources, such as Talking Mats, may be useful in supporting some individuals to think through the ACP process and to make their thoughts and wishes known.

ACP relies on the person being competent to share in the planning process and so needs to be considered early in the care of anyone where decision-making capacity is likely to fluctuate or decline over time.

## Legal issues

### Advice about discussing Power of Attorney

Having a Power of Attorney helps plan what another person can do for the individual in the future, should they become incapable of making decisions about their own affairs. This might be a family member or a close friend.

A Continuing Power of Attorney and a Welfare Power of Attorney are written, legal documents giving someone else (the attorney) authority to take these actions or make decisions on their behalf (the granter). All the decisions made must be those of most benefit to the person.

Powers relating to the granter's financial and property affairs are known as "Continuing Powers" and may be given with the intention of taking effect immediately and continuing if the granter loses capacity or beginning once the granter loses capacity.

Powers relating to the granter's health, personal care and welfare are known as "Welfare Powers" and cannot be exercised until such time as the granter has lost the capacity to make these decisions themselves.

Individuals have scope to grant whatever powers they choose, however as these powers will be strictly interpreted, the individual (the granter) should ensure that the powers granted are specific and cover all the relevant aspects of their affairs, and/or health and welfare.

A Power of Attorney document can contain either Continuing Powers, Welfare Powers or both.

Once the power comes into effect, the attorney or attorneys will have the legal authority to act on the individual's behalf in whatever financial and personal welfare matters were chosen.

A Power of Attorney includes a certificate signed either by a solicitor who is registered to practice law in Scotland or by a medical doctor working in the UK.

To reduce repetition of the process in the future, the individual may want to nominate more than one person as their Power of Attorney in case the person is no longer able to act on their behalf or loses capacity.

For more information, see [www.publicguardian-scotland.gov.uk/power-of-attorney](http://www.publicguardian-scotland.gov.uk/power-of-attorney).

## Advance Directive

"Advance Directive" is a Scottish term, but in other parts of the UK these documents are also called Advance Decisions or Living Wills.

An Advance Directive is a document that allows a person to make a refusal of treatment in advance of a time when they cannot communicate their wishes, or do not have the capacity to make a decision. It only comes into effect if either of these situations occurs.

A person can use an Advance Directive to refuse any treatment, including life-sustaining treatment such as resuscitation, artificial nutrition and hydration, or breathing machines. An Advance Directive enables health and care professionals to know what the individual's wishes are even if they cannot tell them, for example if they had severe dementia or were in a coma.

A person can also use an Advance Directive to set out the treatments that they do wish to consent to if they lose capacity. There is no legal obligation for health and care professionals to give this treatment, but it is important to recognise the individual's wishes as it helps the health and care professionals to gain a better understanding of exactly how the person would like to be treated.

Although Advance Directives are not legally binding in Scotland, health and care professionals should take them into account when deciding on how to treat the person. Family and friends can also use them as evidence of the person's wishes.

A person cannot use an Advance Directive to:

- ask for their life to be ended
- refuse the offer of food and drink by mouth or refuse basic care that attends to their comfort, pain and/or personal hygiene
- nominate someone else to decide about treatment on their behalf. (nominating another person to make decisions about their health and care is done by making a Welfare Power of Attorney), or
- demand certain treatments that may not be appropriate to their condition or situation.

Forms must be signed and completed in the presence of witnesses and witnesses must also sign and date the documents.

The Advance Directive should be amended or updated if there are any significant changes in the person's views, situation or health.

If an Advance Directive is something a person would like to consider, they can read more about Advance Directives using the web link below.

<http://compassionindying.org.uk/wp-content/uploads/2014/11/AD02-Understanding-Advance-Directives-Scotland.pdf>

## **Mental Health (Care and Treatment) (Scotland) Act 2003**

### **Named Person**

If an individual needs treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, they can choose someone to help protect their interests.

This person is called a Named Person. Anyone aged 16 or over can choose a Named Person.

The Named Person can make important decisions about their care if they are unable to decide for themselves.

An individual can have an independent advocate and a Named Person. The independent advocate or a professional involved in the individual's care cannot be the Named Person.

The Named Person has a right to be consulted about some aspects of the individual's care and treatment and can also make applications on their behalf to a Mental Health Tribunal.

If no nomination is in place, a carer or relative will automatically become the Named Person.

## Advance Statement

Under the Mental Health (Care and Treatment) (Scotland) Act 2003, an individual can write an Advance Statement when they are well, stating how they would like to be treated if they become ill in future.

If a person becomes unwell with a mental illness, they may need treatment. Sometimes, when people are very unwell, they are unable or unwilling to consent to treatment.

In some cases, the treatment may be given even if the person doesn't want it.

Anyone who makes decisions about someone's treatment, like doctors or a Tribunal, should read the person's Advance Statement and consider their wishes.

An Advance Statement is not a guarantee that the person's wishes will be followed, but it is a guarantee that they will be taken into account. An Advance Statement should be witnessed and signed by a health or care professional.

It is a good idea to review an advance statement every six or 12 months to make sure it is up to date.

It is important to recognise that an individual may have a Named Person under the Mental Health Act and consider the role of independent advocacy.

## Welfare Guardianship

Welfare Guardianship refers to a court appointed guardian who can make decisions on behalf of any adult who has been assessed as “lacking capacity”. This assessment is carried out by a doctor who has deemed that the adult is unable to make decisions about their own welfare. The guardian is permitted to make decisions about various welfare issues, including where a person lives, as well as about their personal and medical care. Welfare Guardianship differs from Power of Attorney in that the order is granted after the adult has been assessed as lacking capacity; the adult does not instruct the appointment of the guardian. A Welfare Guardian can be a relative, friend, carer or even the local authority. The law that sets out the role and responsibilities of guardians is the Adults with Incapacity (Scotland) Act 2000 (see flowchart in Appendix 4).

## Capacity

Mental capacity is a person’s ability to make decisions for themselves about a particular matter. Having “capacity” means having the ability to understand and retain information relating to the decision, understanding the consequences of any choice they make, taking that information into account, and being able to communicate their wishes.

Reduced mental capacity can be due to a wide range of issues, including:

- delirium
- dementia
- a mental health problem
- a brain injury
- stroke, or
- medication.

Adults with Incapacity (AWI) forms completed for individuals who no longer have decision-making capacity allow appropriate care to be given. See Certificate of Incapacity and Treatment Plan for Patients in Appendix 5.



# Appendix 1: DNACPR form

## DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)



Name: .....  
 CHI/DoB: .....  
 Address: .....  
 ..... Postcode: .....

Previous discussions may be recorded in the Key Information Summary (KIS); *this should always be checked.*

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. This decision applies *only to CPR treatment*. All other appropriate treatment and care will be given (2222 or 999 calls may still be appropriate when immediate medical help is needed in an unexpected emergency).

**Select reason for DNACPR decision: (please choose only A or B). Within Section A or B select the relevant communication or decision-making strategy by ticking the appropriate option**

### A CPR will not be successful and is not a treatment option for this patient

Explain why: .....

The patient is aware of this decision.

Yes  Conversation date and where documented .....

No  Reason (e.g. lack of capacity, judgement of harm to patient).....

.....

The welfare attorney/guardian and/or relevant other is aware of the decision.

Yes  Name(s) ..... Date.....

No  Reason (e.g. reasonable efforts to contact unsuccessful so far).....

.....

*The presumption is that the patient, and those close to the patient who lacks capacity, will be aware of the DNACPR decision – see Decision-making Framework for valid exceptions. Where the conversation has not yet happened, the full explanation and a clear plan to revisit this must be documented in the clinical notes.*

### B CPR could be successful but the likely outcome would not be of overall benefit to the patient. (The patient's informed views and wishes are of paramount importance.) One of the following boxes must be ticked:

The patient has capacity for the decision

and does not wish CPR to be attempted.

and does not wish to discuss CPR decisions at the moment. Decision has been made by clinical team in discussion with relevant others (name below) where confidentiality allows.

Name(s): .....

Explain: .....

**(A clear plan to revisit this must be documented in clinical notes).**

The patient does not have capacity for this decision

but has a valid advance healthcare directive applicable to the current circumstances.

but has a legally appointed welfare guardian/attorney (Name: .....)  
 who agrees that CPR would not be of overall benefit for the patient.

and no legal welfare guardian/attorney can be identified. Decision has been made by clinical team in discussion with relevant others: (Name(s): .....)

Explain: .....

**Document capacity assessment and all discussions clearly in clinical notes.**

### NAMES OF MULTIDISCIPLINARY TEAM MEMBERS INVOLVED IN THE DECISION

Healthcare Professional recording this DNACPR decision

Print:

Sign:

Date:

Responsible Senior Clinician (Dr or Nurse)

Print:

Sign:

Date:

This original DNACPR Form should follow the patient (e.g. on admission to, discharge from or transfer between hospitals) with the agreement of the patient and/or relevant others where appropriate.

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) \*

**Review of decision:**

- Review not needed as decision will remain clinically appropriate until end of life.  
 Review needed on clinically appropriate basis.

Review Date	Responsible Clinician (print & sign)	Outcome of DNACPR review (circle review decision)		Plan for next review
		still applicable	reversed	
		still applicable	reversed	
		still applicable	reversed	
		still applicable	reversed	
		still applicable	reversed	

NB. Good practice guidance recommends review of the decision on transfer of clinical responsibility (e.g. hospital to community) **for all patients**.

Reversal of a DNACPR order should be recorded on the form which should be scored through with a permanent marker **and** the word "reversed" written clearly across both sides of the form which should then be filed in the back of the clinical notes.

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**Communication with healthcare professionals and social carers – who has been informed of the DNACPR decision?**

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	Not Applicable	Names	Date informed	By whom
General Practitioner				
Community Nursing Team				
Ward Team				
Care Provider				
Other				

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**Communication with Ambulance Crew**

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All other types of supportive care should be given as appropriate as with any other patient where there is a deterioration in clinical condition. If, whilst in transit, the patient's condition suddenly deteriorates such that death occurs or is imminent, please contact:

Name and tel no: ..... and take the patient to:

.....

Signed: ..... Name: ..... Date: .....

GP name/address: .....

..... Postcode: .....

Where it has not been possible to have a discussion to allow the DNACPR Form to be at home with the patient (because the conversation would cause harm) it should not be given to the ambulance crew but should be shown to them prior to the journey. The information that the Form is not going home with the patient, and the reason why, **must be communicated to the GP so that the KIS can be updated**.

## Appendix 2: CYPADM form

### CHILDREN/YOUNG PEOPLE ACUTE DETERIORATION MANAGEMENT (CYPADM)

Full Name:.....  
 Date of Birth/CHI Number:.....  
 Address:.....  
 ..... Postcode:.....  
 GP Name & Address:.....  
 Telephone no:..... Postcode:.....



This **CYPADM** form **must** be used for children/young people before their 16th birthday.  
 This **CYPADM** form **could** be used for selected young people after their 16th birthday.

**This Individualised Plan is for use in ALL AREAS**  
**Home, Hospitals, Emergency Departments, Schools, Ambulance Services,**  
**Hospices, Respite Care Facilities.**

Children/young people must continue to be assessed, managed and receive treatments that are appropriate for their health and comfort irrespective of their resuscitation status. A more detailed Anticipatory Care Plan may also be in place for some children/young people.

**In the event of a sudden collapse or deterioration, the following measures would be appropriate to consider where clinically indicated.**

(Clinician completing form must tick actions agreed and score out the actions not required)

Senior clinician/carer attending should decide whether to call resuscitation back up.  
 (2222 in hospital or 999 out of hospital)

- Attempt full resuscitation
- Mouth to Mouth/ bag & mask ventilation
- Suction upper/oral airway/tracheostomy tube
- Administer O<sub>2</sub> until looks comfortable
- Comfort and support to the child and family
- No active resuscitation**

Additional information:

Responsible Consultant (mandatory):.....

Signature (mandatory):..... Bleep..... DATE:.....

**This management plan has been fully discussed and agreed with**

Name:..... Relationship:.....

Co Signatures:(optional)

1. Patient/Parent/Witness Signature:..... Date:.....

2. Patient/Parent/Witness Signature:..... Date:.....

Review Date for CYPADM

Responsible Clinician

This form should be reviewed as clinically indicated or at least annually.

CHILDREN/YOUNG PEOPLE ACUTE DETERIORATION MANAGEMENT (CYPADM)

## Ambulance Crew Instructions

In the event of a **sudden collapse or deterioration** please see the detailed instructions on the other side of this form.

If, whilst in transit, the patient's condition suddenly deteriorates such that death occurs or is imminent, please

Contact (name & telephone no.).....and  
take the patient to.....

**Thank you for your cooperation in this matter.**

Signed (Nurse or Dr): .....

Name: .....Date:.....

## For patients at home or being discharged to home or hospice

- The original CYPADM Form should go home with the child/young person on discharge.
- The child/young person (if appropriate) and the parents/guardians of the child/young person must be aware of the CYPADM Form and understand its purpose and how it may be helpful in an emergency.
- The appropriate GP/District Nurse (DN)/Out of Hours (OoH) Services/ Children Community Nurse (CCN) must be made aware that a CYPADM Form is in place.
- If school, hospice or respite care facilities are involved in ongoing care then each must also know about the CYPADM Form.
- A copy of the CYPADM Form should be with the child/young person at ALL times.
- Where a CYPADM Form is not with a child/young person everyone should be clearly aware that emergency services will provide a full emergency /resuscitation response if called to attend.

**NB: It is essential that the GP, DN and OoH, CCN services are aware of the Children/Young People Acute Management Deterioration Form (CYPADM).**

This form should be reviewed as clinically indicated or at least annually.

## Appendix 3: ReSPECT

**ReSPECT** Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

**1. Personal details**

Full name

Date of birth

Date completed

NHS/CHI/Health and care number

Address

**2. Summary of relevant information for this plan (see also section 6)**

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

**3. Personal preferences to guide this plan (when the person has capacity)**

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

**4. Clinical recommendations for emergency care and treatment**

Focus on life-sustaining treatment as per guidance below  
clinician signature

Focus on symptom control as per guidance below  
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

**SPECIMEN COPY - NOT FOR USE**

CPR attempts recommended  
Adult or child  
clinician signature

For modified CPR  
**Child only, as detailed above**  
clinician signature

CPR attempts **NOT** recommended  
Adult or child  
clinician signature

ReSPECT

ReSPECT

ReSPECT

ReSPECT

ReSPECT

ReSPECT

ReSPECT

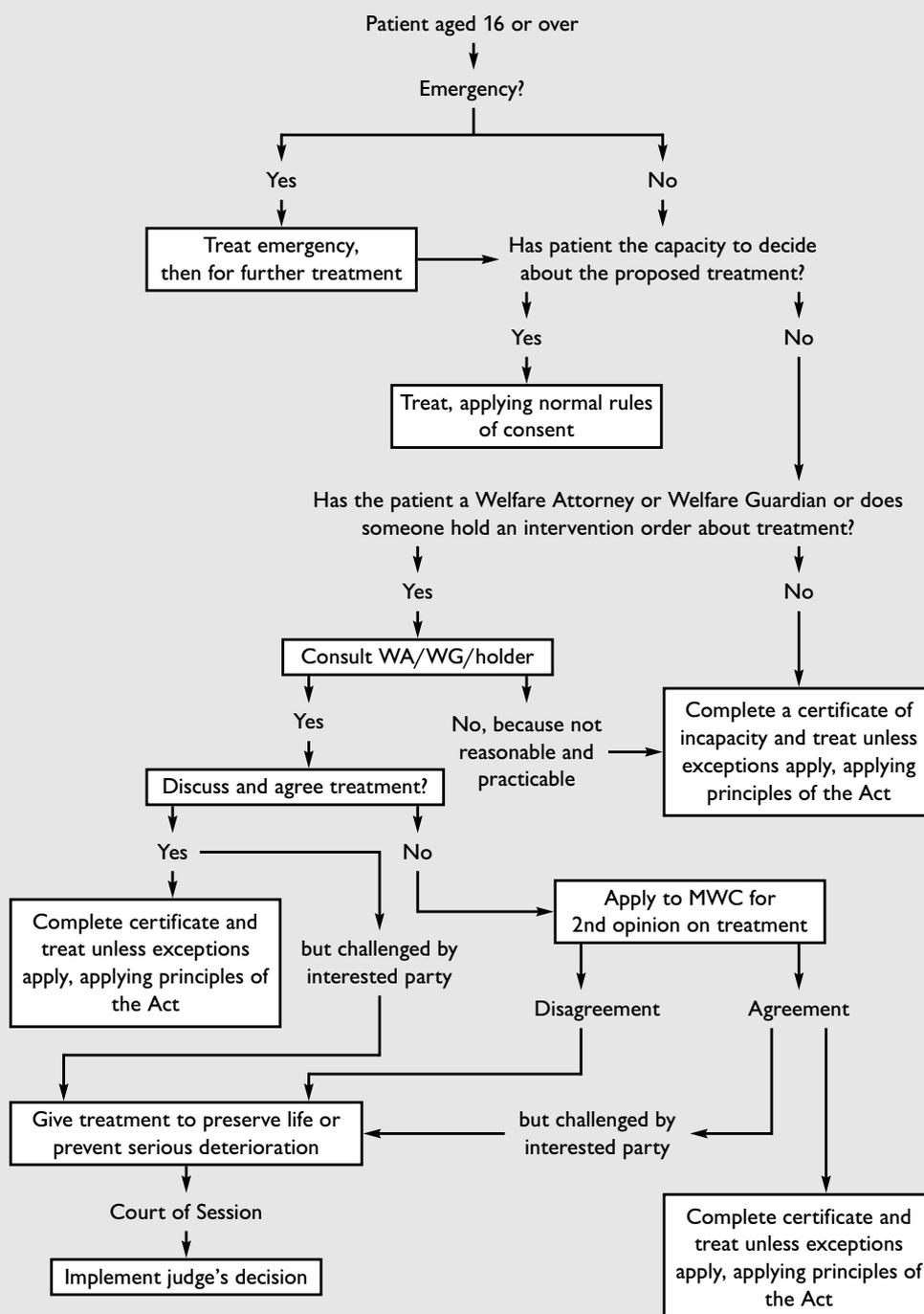
ReSPECT

ReSPECT

# Appendix 4: Adults with Incapacity

## (Scotland) Act 2000 Flowchart

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



Astron B24025 05/02

# Appendix 5: Certificate of Incapacity and Treatment Plan for Patients

## ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

### Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I [redacted] (name)  
of [redacted] (address)

\*am the medical practitioner primarily responsible for the medical treatment of; or

\*am a person who is \*a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

[redacted] (name)  
of [redacted] (address) D D M M Y Y (date of birth)

for whom the \*guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is [redacted]

I have examined the patient named above on D D M M Y Y (date). I am of the opinion that \*he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

[redacted]

because of (nature of incapacity) [redacted]

[redacted]

This incapacity is likely to continue for [redacted] months.

\*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

D D M M Y Y (date of examination) until D D M M Y Y, being a period which does not exceed one year from the \*date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

\*I am of the opinion that (a) \*he/she is suffering from \*a severe or profound learning disability/dementia/a severe neurological disorder; and (b) \*what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the \*date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above 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 2000 Act.

Signed [redacted] Date D D M M Y Y

\*delete as appropriate

**Treatment plan for patients**

receiving ongoing treatment under the terms of Part 5 of the Adults with Incapacity (Scotland) Act 2000.

Name of patient..... Date of birth...../...../.....

Address.....

.....

I have examined the patient named above on...../...../.....(Date) and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention.

<b>Disorder/intervention</b> (See note A)	<b>Capacity</b> C = capable I = incapable
1. Fundamental healthcare procedures (see note B)	

I have consulted the following people over this treatment plan and over the patient's capacity (see note C):

Name..... Designation.....  
Address.....

Name..... Designation.....  
Address.....

Signed.....

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