

Deciding Right

Professional FAQs (v12)

What is Deciding Right?

Deciding right enables professionals and organisations to be compliant with key legal and clinical frameworks. It does this by:

- emphasising the partnership between the individual, carer or parent and the clinician
- placing the Mental Capacity Act (MCA) at the centre of shared decision-making
- enabling professionals and organisations to comply with the MCA by filling the gap in practice, not just the knowledge gap
- recognising the individual with capacity as key to making care decisions in advance
- empowering the individual who lacks capacity to have decisions made in their best interests
- introducing emergency health care plans as an important adjunct in all settings to tailor care to the individual with complex needs
- ensuring that, wherever possible, documentation and information is suitable for all ages (children, young people and adults)

Has the initiative and documentation received legal approval?

Yes. All the principles and documentation have been approved by the North East SHAs solicitors, Hempsons of London.

What is the authority of this initiative?

This has been a north east and Cumbria initiative, but its authority comes from legislation (the 2005 Mental Capacity Act), and the 2014 BMA/RC/RCN *Decisions Relating to Cardiopulmonary Resuscitation*.

Where can I get the full policy and copies of the documentation?

From

<http://www.northerncanceralliance.nhs.uk/pathway/palliative-and-end-of-life-care/supportive-palliative-and-end-of-life-care-resources/>

Who keeps the documentation?

Documentation is held by the patient, unless the patient has given these to a carer for safe-keeping. In hospital, DNACPR forms are usually kept at the front of the clinical notes.

Can copies of the documentation be used for bedside decisions?

No. Only the original documentation can be sure of being the current decision. Copies can be made for archival purposes only.

Can the documents be generated by e-record systems?

Writeable versions are available that can be completed online, but the patient details cannot be populated by current patient data systems. These e-forms must then be printed (DNACPR forms must be printed in colour) and signed. Only this original, signed document can be used for bedside decisions.

Can organisations use their own documentation?

Yes, but.... these could only be used in their own settings. Only the regional *Deciding right* forms are applicable in all settings. From April 2013 the North East Ambulance Service (NEAS) will only recognise original regional forms.

Where should the documents be placed?

For inpatient settings the original document should be at the front of the clinical care record. At home the document can be kept in the front of the community care record. The 'yellow envelope' scheme is using bright yellow A5 envelopes in which to place important documents.

Is an easy read leaflet available?

Yes, from

<http://www.northerncanceralliance.nhs.uk/deciding-right/deciding-right-resources/>

Will this greatly increase workload?

No.

- The need for 'advance care planning' should happen as part of existing dialogue with patients.
- Only some patients will want to write an advance statement (for which they do not require a professional) and only a small number will want to write an ADRT (again there is no requirement for any professional to be involved, but if one is involved it does not have to be a GP)
- Fulfilling the requirements of the Mental Capacity Act, in our experience, saves time. For example, using the MCA best interests process can avoid repeated case conferences, complaints and angry conversations caused by poor communication.
- DNACPR decisions do not have to be reviewed by GPs- suitably experienced nurses can do this if local policy allows.
- DNACPR decisions can be initiated by a suitably experienced nurse who is the responsible senior clinician if local policy allows this.

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Capacity and best interests

CAPACITY and BEST INTERESTS

Do I have to test capacity in all individuals?

No, the Mental Capacity Test requires you to assume an individual has capacity unless a care decision needs to be made and

- there is a suspicion of an impairment or disturbance of mind or brain or
- this is a young person aged 15 years or less or
- the individual is aged 16-17 years and needs to decide on organ transplantation

Can anyone test capacity?

Yes. Any individual providing care or treatment has a duty to test capacity if this is needed.

Isn't testing capacity complicated?

Not usually. Capacity is assessed by estimating that an individual can do all the following:

1. Understand the information
2. Retain the information
3. Weigh up the information
4. Communicate their decision

Do I have to test capacity for all care decisions?

Yes, if there is a suspicion capacity is decision- specific, ie. an individual can have capacity for some decisions but not others

Even for simple care decisions like washing?

No. Even if an individual lacks capacity, their opinion must be taken into account. Therefore verbal consent is sufficient for most simple care decisions.

Isn't it sufficient for me to decide in the individual's best interests?

No. The Mental Capacity requires all those who know the individual to estimate, as a minimum, the following:

1. Have you consulted others?
2. Have you avoided discrimination?
3. Did the individual make any decision in advance?
4. Could capacity return in time for a decision?
5. Have you included the individual if possible?
6. Have you ensured death is not the motivation?
7. Have you considered the least restrictive option for the individual?
8. Are there obligations and emotional bonds the individual would have taken into account?
9. What decision would the individual have made in their best interests?

What is there is no-one to speak for the individual?

If time allows, an IMCA (Independent Mental Capacity Advocate) must be appointed

Is all this possible in an emergency?

No. Emergency treatment must never be delayed.

Does all this need to be documented?

Yes. Use form MCA1&2 available on

<http://www.northerncanceralliance.nhs.uk/deciding-right/deciding-right-regional-forms/>

Next page: Advance statements and ADRTs

ADVANCE STATEMENTS and ADVANCE DECISIONS TO REFUSE TREATMENT

Are living wills and advance directives still valid?

Any statement made by an individual with capacity is relevant when that person loses capacity. However, using the old terminology can cause confusion and delay in trying to decide the legal status of the statement. Most living wills were advance statements, and most advance directives were advance decisions to refuse treatment. It is better if these are re-written as advance statements or advance decisions to refuse treatment.

Is an advance statement legally binding?

No. However, professionals are legally bound to take an advance statement into account as part of the Mental Capacity Act best interests process if the individual has now lost capacity for those decisions.

Is an advance refusal of treatment legally binding?

Yes, if the decision is valid and applicable.

Should professionals advise patients making advance statements and advance decisions to refuse treatments?

Yes, if the patient wishes this. It can be helpful for a professional to advise the patient, especially for advance decisions that refuse life-sustaining treatment.

Should professionals witness an ADRT?

No. The witness is only witnessing the patient's signature, not the decisions. NHS Trusts advise against staff witnessing legal documents if they are involved in their care.

Can an advance statement or ADRT be written for someone who has lost capacity?

No. Only individual's with capacity for those decisions can make such statements.

Does an advance statement, ADRT or lasting power of attorney have any authority if an individual still has capacity?

No. The decision of a person with capacity almost always takes precedence.

Can an advance care plan be used?

No. Planning care in advance is often called 'advance care planning'. Although this describes the dialogue, there is no entity called an advance care plan that has any definition or legal status. There is no mention of 'advance care plans' in either the Mental Capacity Act.

Next page: DNACPR

Do Not Attempt CPR (DNACPR)

Is a DNACPR form legally binding?

No. A DNACPR decision is advisory only. The responsibility for the clinical decision rests with the person present at the time of the arrest, not the person who signed the DNACPR. This means that:

- in the absence of a DNACPR a clinician is not obliged to start CPR if they are as certain as they can be that it cannot succeed
- in the presence of a DNACPR a clinician must start CPR if they are as certain as they can be that the circumstances are different to that on the DNACPR form and CPR could succeed

Can the patient's DNACPR be used in any setting? Yes. On changing settings it is good practice to review the decision (see below), but a new form does not have to be written.

Is a DNACPR the best way to prevent hospital admission?

Only if a cardiac or respiratory arrest is anticipated. For many patients an Emergency Health Care Plan (EHCP) is a much more individualised way of making what actions should take place in an emergency.

Who should sign a DNACPR?

This must be signed by a senior responsible clinician. National clinical and legal guidance allows this to be a nurse, but it is up to each organisation to define this role.

Is the person signing a DNACPR responsible for actions at the future arrest?

No. The DNACPR is an advisory note only. Only the person present at the time of an arrest is responsible for the decisions.

What does reviewing a DNACPR entail?

A review is simply to check that the reasons for the original DNACPR are unchanged. *If the circumstances are unchanged*, the DNACPR is initialled and continues- nothing else needs to be done. *If a patient is stable or has improved* consideration should be given to cancelling the DNACPR - this could be discussed at the next team meeting. *A new DNACPR decision and form* is only needed if the reasons for the DNACPR have changed. All of this is no different to the current situation with DNACPR decisions, but with the important improvement that the review date is now documented.

How often should a DNACPR be reviewed?

If circumstances change or there is a change of care setting it should be reviewed within 5 days, ideally within 24 hours. Good practice is to review a DNACPR at regular intervals dependent on the individual's needs, but this be no more than 12 months.

Who can review a DNACPR decision?

Even if an organisation decides only a doctor can initiate the form, a nurse can still review the decision. If the nurse prefers, they can check this with the senior responsible doctor by phone or during a routine team meeting.

Will reviewing DNACPR decisions increase workload?

No. For most patients the reasons for the DNACPR will not have changed and the form only needs to be initialled. The process is simple, can be completed by any senior responsible clinician, and can be completed during routine home or care home visits.

Do some DNACPR decisions need consent from the patient?

Yes. Consent for CPR must be obtained from any patient with capacity for a CPR decision in whom an arrest is anticipated *and* CPR could be successful.

Can all patients be consented for DNACPR?

No. Patients who cannot be consented are those:

- who lack capacity for this decision
- in whom CPR has no realistic chance of success
- in whom an arrest is not anticipated in the current circumstances

However, communication with these patients should continue at their pace and control and may include information about the DNACPR if they wish to discuss CPR.

What happens in those who do not have the capacity to make a CPR decision?

Any decision must be made following the 9 point checklist required by the Mental Capacity Act (see the MCA1 & 2 form on the *Deciding right* website). The exception to this is an emergency requiring immediate treatment where the clinician must make a rapid decision based on the information they have but, if they are in any doubt, they should start CPR.

What happens with patients in their own home?

Explaining the reason for the DNACPR is necessary for patients at home since the patient and their partner or relative need to know the purpose of the form. Some patients with capacity to make a CPR decision will not wish to discuss this and they cannot have a DNACPR.

How do you inform a patient going home with a DNACPR?

Usually such patients will have chosen or requested to return home knowing that they are likely to die at home. In this case, the DNACPR is not documenting a decision but the fact that this treatment (CPR) cannot succeed. This is likely to have been discussed as a continuous dialogue over days or weeks. Such patients do not usually wish to return to hospital and they will view a DNACPR as a means of preventing readmission. The key is dialogue, not a sudden announcement that they are DNACPR.

Can a DNACPR be ignored?

Yes. If the person present at the arrest believes that the arrest is reversible, CPR could benefit the individual, and the patient did not make an advance decision to refuse CPR, then they should start CPR.

Does a DNACPR cover treatment other than CPR

No. All other treatments require different decisions and treatments such as fluids and antibiotics can still be appropriate in the presence of a DNACPR decision.

Isn't an ADRT refusing CPR the same as a DNACPR?

No. An ADRT refusing CPR can be legally binding if it is valid and applicable, while a DNACPR is only an advisory note. However, because it takes time to check the validity and applicability of an ADRT, an ADRT that refuses CPR should always be accompanied by a DNACPR form.

Next page: Emergency health care plans

Emergency Health Care Plans (EHCP)

What is an EHCP?

An EHCP provides the means of communicating agreed responses to anticipated emergencies.

When can an EHCP be used? This is invaluable for all individuals in who a crisis or emergency can be anticipated. It allows for more individualisation of decisions and is preferable for to a DNACPR for and individual with complex needs and for many residential and nursing home patients.

Is an EHCP the same as a ceiling of care?

No. There can never be a ceiling of care, since care must always be provided. However, there can be limits to the escalation of treatment, or a need to make clear that the patient should receive all possible treatments.

Is an EHCP only about limiting treatment?

No. There are many individuals for whom the EHCP will make clear that all possible treatment should be offered. This can be invaluable for individuals with complex physical, mental or cognitive disabilities.

Can an EHCP state that CPR should not be offered? No. At present, a DNACPR decision can only be documented on a DNACPR form or an ADRT.