Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy and Procedure, including Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Guidelines and Procedure (N-012)

Version Number:	4.2
Author (name & job title)	John Sands, Resuscitation Officer Tracy Robinson, Manager at Granville Court
Executive Lead (name & job title):	Hilary Gledhill, Director of Nursing
Name of approving body:	Quality Committee (V4.0)
Date full policy approved:	2 May 2018
Date Ratified at Trust Board:	May 2019
Next Full Review date:	June 2025

Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*13 July 2022* (QPaS)
Date EMT as approving body notified for information:	*August 2022*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

Ongoing developments and continuous improvements in health care mean that many people are able to live well, for longer than ever before. For the vast majority, the over-riding aim of care and treatment in an emergency situation is to return them to their pre-emergency level of health, or as near to that as possible. However, recent advances cannot extend life, or stave off ill health, indefinitely.

Many people want to be able to influence the treatment that they receive, and take part in decision-making about treatment, whether currently in a state of ill health, or in anticipation of future ill health. For others who lack the mental capacity to make those decisions themselves, decisions about the treatment that they receive may have to be taken by others.

Cardiopulmonary resuscitation (CPR) is one treatment that has received much attention, and that has undoubted potential benefits for some people. However, for many people, CPR will have a minimal or no chance of success, and of thereby providing benefit, to the person receiving it. Other people may make an informed decision that they do not wish to receive attempted CPR should they suffer cardiorespiratory arrest, even if it might have a good chance of success/benefit in their situation.

Recent attention has been given rightly to treatments other than CPR that may be relevant when people are seriously ill; recommendations about whether these treatments should or should not be given to a person are often referred to as ‘emergency treatment plans’ or ‘treatment escalation plans’ as they concern recommendations about the appropriateness for each individual of starting or not starting, continuing or not continuing, certain treatments. These treatments may include, for example, clinically assisted hydration or nutrition, assisted ventilation, or intravenous antibiotic therapy.

Decisions about whether or not to initiate CPR are one element of these ‘emergency treatment plans. Decisions about CPR and other emergency treatments are often made as part of the process of ‘advance care planning’: a process through which people who are able to can express their preferences and plan for their future care, and are helped and supported to do so, in anticipation of a time when they may be unable to participate in decision-making about the care that they receive.

Increasing evidence suggests that considering a decision about whether or not to attempt CPR and discussing CPR in the context of overall goals of care and other types of care and treatment that might be needed leads to fewer, less severe harms compared to focusing only on ‘Do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions (Fritz et al, 2013, Perkins et al, 2016)

Several factors are important to consider when these decisions are made. These include the chances of the treatment in question being successful; the wishes, beliefs and values of the person who would like to receive, or not to receive, a particular treatment; the ability (mental capacity) of the person to make decisions about their care; any legally binding refusals of treatment that they may have made, or the views of proxy decision-makers that have been appointed to act on their behalf. Documented evidence of a person’s decisions or wishes is especially important and helpful to those who have to make decisions about potentially life-sustaining treatments. Many decisions that relate to emergency treatment need to be taken with urgency, often in a situation where a person lacks mental capacity to make or contribute to making decisions at that particular time.

Knowing what a person would have wanted to happen to them keeps them at the centre of care, even when they may not be available to make their wishes known.

2. SCOPE

This policy applies to all patients in whom DNACPR and/or ReSPECT decisions are being considered. For all those at risk of deterioration or cardiac arrest or who want to have their wishes documented, a conversation regarding treatment options and focus of care should be held and a DNACPR and/or ReSPECT form should be completed. The aim of the DNACPR/ReSPECT process is to protect patients and support staff in making complex recommendations and to ensure all decisions/discussions are clearly recorded.

This policy and procedures must be made available to patients on request.

3. DEFINITIONS

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) addresses treatment planning in relation to emergency, potentially life-extending treatment, including CPR. It should be considered for those patients who are at risk of a clinical deterioration that may place their life at risk. These patients may already have an existing life limiting illness, such as advanced organ failure, or cancer. The scope of ReSPECT can cover other treatments-for example, antimicrobial therapy in those at risk of infection, ventilation in those at risk of respiratory failure or artificial nutrition/hydration in those at risk of aspiration. Additionally, patient wishes may lead to a ReSPECT document being considered, discussed and used, even in the absence of advanced, or indeed any, illness. ReSPECT aims to promote more conversations between patients (and/or their families) with clinicians, leading to shared decision making (where possible), better advanced planning, good communication and documentation and better overall care.

Do Not Attempt Resuscitation (DNACPR)
This is a decision not to attempt CPR, made and recorded in advance on a ReSPECT form, to guide those present if a person subsequently suffers sudden cardiac arrest or dies.

A DNACPR decision may be made and recorded:

- at the request of the person themselves
- as a shared decision (made by the person themselves and their doctor and/or other healthcare team members) that the likelihood of CPR being beneficial in their current situation would not outweigh the potential burdens and risks of receiving attempted CPR
- by the healthcare team, because CPR should not be offered to a person who is dying from an advanced and irreversible condition and therefore CPR will not prevent their death
- by the healthcare team because the person themselves is not able to contribute to a shared decision and a decision has to be made in their best interests

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The Chief Executive is responsible for ensuring that resources and mechanisms are in place for the overall implementation, monitoring and review of this policy.

Medical Director and Director of Nursing, Allied Health and Social Care Professionals
The Medical Director and Director of Nursing, Allied Health and Social Care Professionals are responsible for ensuring that the policy is reviewed, approved and monitored by the appropriate Trust-wide group. The Director of Nursing, Allied Health and Social Care Professionals and the

Medical Director are the executive leads for this policy. They are responsible for:

- ensuring all medical and nursing staff are aware of this and other policies and guidance which relate to this policy
- assuring the Board that the policy is acted upon through delegation to the appropriate directorates and committees

Resuscitation Officer
The Resuscitation Officer will report, give advice and provide assurance to the board on all matters relating to any resuscitation activities undertaken within the Trust.

Divisional Clinical Leads
Divisional Clinical Leads are required to ensure that:

- all medical and nursing staff are aware of this and other policies and guidance which relate to this policy
- adequate training is given to allow medical and nursing staff to safely implement the policy
- staff have access to resources as identified in the policy

Divisional Clinical Leads will ensure the dissemination and implementation of the policy within their area of responsibility and will ensure that staff have access to training.

Modern Matrons
Modern Matrons will ensure that they monitor the compliance of this policy in all areas of their responsibility.

Charge Nurses/Team Managers/Ward Sisters
Charge nurses, team managers and ward sisters will ensure that:

- mechanisms are in place and operational for the training and updating of all qualified/unqualified clinical staff
- equipment is checked and maintained to the required standard
- all staff have the competencies to an understanding of ReSPECT

All Staff
All staff, including support services and non-clinical areas, should familiarise themselves with this policy and attend the relevant training as specified in the mandatory training needs analysis.

All Consultants and Clinicians in Charge of Patients' Care
All consultants and clinicians in charge of patients' care will:

- undertake appropriate education and maintain the required skills
- retain overall responsibility for decisions relating to resuscitation of that patient and ReSPECT orders
- ensure that they are aware of the contents of this policy and supporting policies

5. PROCEDURE

5.1. Key Principles of ReSPECT

ReSPECT recommendations must be made on the basis of an individual patient assessment and in consultation with the patient, save in the exceptional circumstance that consultation is likely to cause physical or psychological harm to that patient.

ReSPECT must be reviewed regularly. A review will be required:

- whenever changes occur in the patient's condition

- if there is a change in the patient's expressed wishes
- whenever the patient is admitted, discharged or transferred from one healthcare provider to another

The frequency of review should be determined by the health professional in charge of the patient's care and will be influenced by the clinical circumstances of the patient. Prior to changing/cancelling the ReSPECT, a discussion should take place with the patient/family and amongst the multidisciplinary team including the consultant responsible for the patient's care.

Unless cancelled, ReSPECT covers hospital and community care episodes.

ReSPECT is not a legally binding document. It does not override clinical judgment in the event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged when the recommendation was made, provided that there is not a valid and applicable advance decision expressly refusing such intervention. In an emergency, the presumption should be in favour of CPR if this has a realistic chance of prolonging life. Examples for overriding ReSPECT in favour of treatment include choking and blocked tracheostomy.

In the event of a patient undergoing general anaesthesia (such as within the ECT suite), the ReSPECT form should be acknowledged, reviewed and discussed with the patient and clinical team. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision as part of the ReSPECT recommendation should be reviewed in accordance with the Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period (Association of Anaesthetists of Great Britain and Ireland) 2009.

Where there is uncertainty over a ReSPECT (particularly where it relates to CPR) then, in the event of a cardiac arrest, resuscitation should be commenced.

At the time of making a ReSPECT, staff should discuss treatment options and goals of care (e.g. referral to ICU, HDU, antibiotics and NEWS/PAWS scoring etc.) which are relevant to the patient. Recommendations limiting other aspects of care must be clearly and explicitly recorded in the medical record and communicated to the multi-disciplinary team.

DNACPR recommendations relate only to the act of CPR (e.g. chest compressions, ventilations and defibrillation) and do not in itself place any limitations on other aspects of the patients care. However, the ReSPECT process encourages clinicians to explore other treatments and the goals of care with the patient rather than make decisions about CPR in isolation.

A ReSPECT should be made in accordance with the requirements of the Human Rights Act 1998, the Mental Capacity Act 2005 and all professional regulatory bodies. Please refer to Trust guidance on the Mental Capacity Act (Mental Capacity Act and Best Interests Decision Making Policy M-001).

5.2. Principles for Young People 13-18 years

When considering if the young person has sufficient maturity and understanding to participate in making the ReSPECT plan, the principles set out in the Trust's Consent to Assessment, Examination and Treatment Policy (section 5.13 Children and Young people) must be followed.

Failure to consult with the young person with sufficient maturity may constitute a breach of their rights under Article 8 European Convention of Human Rights (ECHR). A ReSPECT should usually be completed and inserted in the young person's notes after consultation with the young person. Only in exceptional circumstances where the treating clinician considers "the patient will be distressed during consultation" and that "the distress may cause harm" will it be reasonable not to discuss a resuscitation status/plan of care with the young person.

Where the patient under the age of 16 lacks sufficient maturity and understanding to participate in making the ReSPECT plan their views should still be taken in to account.

Those holding parental responsibility must be fully involved in both discussing and the decision-making process of ReSPECT. The principles as set out in the Trust's Consent to Assessment, Examination and Treatment Policy must be followed.

Where the patient is 16 years or over and there is a question about a patient's capacity to be involved in discussions about emergency treatments, clinicians must follow the Trust's Mental Capacity Act and Best Interests Decision Making Policy. The plan must be made in accordance with capacity law as follows:

ReSPECT decisions relating to children and young people should be taken with a supportive partnership involving patients, parents and the multidisciplinary healthcare team. However, overall responsibility for the recommendation lies with the consultant in charge of the patients care. If it is not possible to reach agreement between the parties legal advice should be sought.

Specific considerations that may need to be taken into account for young patients receiving treatment for eating disorders are outlined in the separate guidance.

When a young person is admitted with or has a ReSPECT decision made within the Trust both the executive director of nursing and the medical director should be informed of this as soon as is practically possible and the trusts legal department should be made aware of the situation and advice sought were appropriate.

Where a young person is detained under the mental health act and a ReSPECT decision is being considered due regard must be given to the relevant legislation and policy such as the Mental Health Act policy and the Mental Capacity Act and Best Interest Decision Making Policy.

5.3. Principles for Patients with a learning Disability

The terms "learning disability" and "Down syndrome" should never be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause of death on part I of the medical certificate Cause of Death.

5.4. Principles for Non-discriminatory Decision-Making

Decisions must not be made on the basis of assumptions based solely on factors such as the person's age, disability, or on a professional's subjective view of a person's quality of life. Such decisions are unethical and, in some cases, unlawful.

5.5. Responsibility for ReSPECT

The consultant in charge of the patient's care at the time the ReSPECT is made carries responsibility for that recommendation until the patient is formally transferred to the care of another consultant or GP, at which point the receiving senior clinician will assume responsibility. The consultant should be prepared to discuss the recommendation for the patient with other health professionals involved in their care, including the patient's GP. This is particularly relevant when formulating ReSPECT for outpatients or those being discharged.

In their absence, a doctor of a grade ST3 or above can make a ReSPECT recommendation which includes DNACPR on grounds of medical futility. FY2-ST2 grade doctors can only make a ReSPECT recommendation including DNACPR on medical futility grounds having had discussions with an ST3 grade or above. These discussions must be clearly documented in the patient's medical notes.

If a patient who has capacity asks to document their wishes including DNACPR, a registered senior healthcare professional who has had training in the assessment of capacity and consent

and has had this role delegated by a consultant can complete the ReSPECT process.

When the consultant next reviews the patient they should sign to endorse the ReSPECT recommendations.

ReSPECT recommendations should be made in partnership and consensus with patients and the clinical multidisciplinary team.
When a ReSPECT is made in the community by a clinician such as a Macmillan nurse the form should be signed by the patient's GP following a conversation between the two practitioners.

The importance of teamwork and good communication cannot be over-emphasised. Where care is shared between hospital and general practice, the relevant professionals should discuss the issue with each other, with members of the health care team and with the patients and their families as appropriate. A delegated individual should take charge of ensuring that the recommendation is properly recorded and conveyed to all clinical staff involved in the care of that patient.

Recommendations must be based on reliable, up to date clinical guidelines and informed by the discussions had with the patient and relevant family members.

5.6. Resuscitation Recommendations and ReSPECT

DNACPR recommendations are usually only appropriate in three settings:

- Where attempting CPR will not restore the patient's cardiac output, the healthcare team must be as certain as it can be that attempting CPR would be futile. This recommendation should be based on clinical assessment of the patient and relevant guidelines.
- Burdens that outweigh benefits – where the expected benefit is outweighed by the burden
- e.g. terminal illness. This assessment can only be made following discussion with the patient (or relatives if the patient lacks capacity or if declining involvement gives permission for the family to be involved).
- Patient refusal – where CPR is against the wishes of a patient it may be expressed verbally or in accord with a valid and applicable advance decision. A valid advance decision refusing CPR must be made by someone aged 18 or over, who had capacity at the time the advanced directive was completed, be in writing, signed, witnessed and state that the named patient refuses any life-sustaining treatment.

5.7. Making a ReSPECT

Communication and good record keeping are central to the safe and effective use of the ReSPECT policy.

The Resuscitation Council (UK)/RCN/BMA Guidance Decisions relating to cardiopulmonary resuscitation (2016) provides general guidance on deciding when and how approaches to patients and relatives should be made. The circumstances of each patient should be considered and a plan formulated on a case by case basis.

Discussions around emergency treatments should be undertaken sensitively. Clinicians should be responsive to verbal and non-verbal communication signals from the patient which may indicate the extent to which they wish to be involved in these discussions.

Discussion within the healthcare team (doctors, nurses, allied health professionals) should aim to achieve consensus about a ReSPECT.

ReSPECT recommendations should be recorded on the nationally recognised form Electronic or paper version, which in the case of paper should be filed at the front of the patient's medical notes

while in hospital. All sections of the form should be completed, and an entry should be made in the medical notes providing the rationale for the decision by documenting all relevant discussions held with the patient and any relevant others.

The clinician responsible for completing the ReSPECT form must record on Lorenzo under the advance directive function the ReSPECT decision including DNACPR. A scanned PDF copy of the ReSPECT document will be saved to this entry by administration and clerical staff as soon as possible or by the end of the next working day. If discharge takes place over a weekend clinical staff must ensure the ReSPECT form is uploaded onto Lorenzo or system one.
Nursing staff have a duty to record and maintain up to date nursing records of ReSPECT including resuscitation. Robust systems must be in place to ensure effective communication between shifts and whenever a patient is transferred between clinical areas (e.g. ward to ECT/Hull Royal Infirmary).

For non-English speaking patients and their families, to ensure an informed decision can be arrived at, an interpreter will be required to ensure their understanding of the situation. It is not good practice to use relatives as interpreters. To obtain interpreters follow local procedures.

Patients with speech, sight or hearing impairment should have facilities provided to ensure their understanding.

5.8. Essential Aspects of Decision-Making

Each case involves an individual patient and their family with his or her own particular circumstances and it is important to ensure that any recommendations (regarding ReSPECT) are based on these.

Decisions made not to attempt to resuscitate in a particular patient should ideally be made in advance, as part of the overall care planning for that patient and discussed with the family if appropriate.

A recommendation not to attempt resuscitation applies only to CPR. It must be made clear to the patient and the health care team that it does not imply "non-treatment" and that all other appropriate treatment and care will continue to be considered and offered.

Once made, all recommendations must be communicated effectively to the relevant health professionals.

5.9. Implications for Treatment

ReSPECT focuses on treatments to be considered as well as those that are not wanted or would not work.

Consensus amongst all those involved in the ReSPECT process and subsequent recommendation is the preferred aim. If consensus cannot be reached, a clear note of the reasons for the disagreement and the individual or individuals expressing the disagreement should be made. Ultimately, the responsibility to complete the ReSPECT rests with the consultant in charge of the patient's care.

Where the clinical recommendation is challenged or an objection is raised about the ReSPECT by a patient, every effort should be made to reach a resolution through sensitive discussions. If an agreement cannot be reached, a second opinion and or legal review may be necessary.

5.10. Reviews and Revocation

A ReSPECT should be reviewed on transfer of care, in response to any change in the patient’s overall health status or their expressed wishes. The frequency of the reviews should be determined on a case-by-case basis but generally, a ReSPECT recommendation will remain effective unless cancelled.

When a ReSPECT is cancelled the form should be marked through with two parallel lines and the word “**cancelled**” written clearly between the lines. The date, time, name and grade of person revoking the ReSPECT should be recorded on the form. The form should be immediately removed and filed in the correspondence section of the medical notes. **Amended ReSPECT forms must not be destroyed** as they are an important record of discussions and decisions.

Lorenzo must also be amended to maintain contemporaneous records by the clinician cancelling the form.

A note fully recording the reasons for this change in recommendation must be made in the patient’s medical notes.

Medical staff must inform the nurse in charge of the patient’s care whenever a change in a ReSPECT is made.

5.11. Patients with Capacity

The Court of Appeal's decision in R (Tracey) v Cambridge University Hospitals NHS Foundation Trust and others, makes it clear that the patient (and where requested by the patient, the patient's relatives) should be involved in discussions about resuscitation.

Failure to consult with the patient may constitute a breach of their rights under Article 8 European Convention of Human Rights (ECHR). A ReSPECT should be completed and inserted in a patient's notes after consultation with that patient. Only in exceptional circumstances where the treating clinician considers "the patient will be distressed during consultation and that the distress may cause harm" will it be reasonable not to discuss a patient's resuscitation status/plan of care with them.

Harm can be psychological or physical. **Distress alone would not be sufficient grounds not to discuss ReSPECT with the patient/family**. A clinical view that CPR or medical treatment is futile is not a sufficient reason not to inform the patient/family.

In the rare circumstances where a clinician has sufficient grounds to believe discussion with a patient about their resuscitation status would cause that patient harm, that clinician must clearly record the reasons for this in the medical notes. Reasons must be robust and health professionals must be able to justify these.

If a patient indicates that they do not wish to discuss emergency treatments and resuscitation, this instruction should be respected. Where a ReSPECT is made and there has been no discussion with the patient because they have indicated a desire to avoid such a discussion, this must be documented on the form and in the health records, with reasons given.

If a patient with capacity refuses emergency treatments (including CPR) healthcare professionals must comply with their decision and document it in the medical records including details of the discussion and advice given.

Refusal by a patient to allow information to be disclosed to their family and/or friends should be clearly documented and must be respected.

5.12. The Patient who may Lack Capacity

Where there is a question about a patient's capacity to be involved in discussions about emergency treatments, an assessment of that patient's mental capacity must be carried out in accordance with the test set out in the Mental Capacity Act 2005. The starting point when undertaking any capacity assessment is a presumption of capacity. The assessment must be time and decision specific (refer to the Mental Capacity Act and Best Interests Decision Making Policy M-001 for guidance on decision making in patients that lack capacity).

The outcome of a mental capacity assessment must be recorded on the ReSPECT form and the Trust Mental Capacity Assessment documentation completed.

In patients who lack capacity there is a **legal obligation** to consult with relatives/friends/advocate (such as an Independent Mental Capacity Advocate IMCA), when considering a DNACPR recommendation (Winspear v Sunderland NHS Trust). This might mean delaying a DNACPR recommendation until reasonable and practical steps have been taken to consult the relatives.

Such steps may include telephoning at night, which whilst that might be less convenient or desirable than a meeting in office hours, does not mean it is not practicable. In the case of a rapidly evolving clinical scenario when decision making needs to proceed before relatives can be contacted, the following should be documented in the case notes: (1) what attempts have been made to contact relatives; (2) the reasons why the DNACPR/treatment plan recommendation has been made without their consultation; and (3) clear instruction that they are informed as soon practically possible.

If patients lack capacity and have a Power of Attorney for Health (POA) or legal guardian, this person must be consulted about DNACPR decisions.

5.13. If Agreement cannot be Reached

Whilst clinicians cannot be required to give medical treatment contrary to their clinical judgement, and a patient cannot demand treatment, it is unwise to make a ReSPECT recommendation before these conflicts are resolved.

In the event that the clinical team and the patient/POA are unable to resolve these conflicts a second opinion from a consultant colleague must be sought. If this fails to lead to resolution, then advice from the Trust Legal team and/or Safeguarding team should be sought. Out of hours call the site team and on call manager first.

5.14. ReSPECT in Patients Requiring Off-site Transfer and Discharge

Prior to any transfer, the circumstances behind the ReSPECT should be reviewed. The receiving team in the community e.g. GP/community nursing team/hospice/care home should be made aware of the treatment plans.

If the reasons for the ReSPECT remain valid and the patient is considered at risk of deteriorating on route, then the ReSPECT should remain active during the transfer. The transfer team must be made aware prior to transfer.

When arranging an ambulance to transfer a patient with a ReSPECT:

- Contact the respective ambulance control and state that a ReSPECT is in place and whether resuscitation or other emergency treatments should not be attempted by the ambulance crew in the event of deterioration. Advise the patient (and relatives if appropriate) that the ReSPECT will remain in place during the transfer. Record this in the patient's medical record.
- Ensure the advanced directive template has already been completed on Lorenzo and a copy of the form has been scanned and saved as a PDF document for future reference.
- Ensure the GP, community nursing team, nursing home, respite care or other hospital is aware of the ReSPECT recommendation. The original form accompanies the patient.

5.15. Patients Admitted with Existing Decisions

DNACPR recommendations and ReSPECT can only be effective across healthcare settings if it is shared without delay, with relevant healthcare professionals, whose decisions it is intended to inform.

When a patient attends hospital with an active DNACPR form or ReSPECT it should be reviewed with the patient. The nature of any review of ReSPECT will depend on the particular clinical circumstances of the patient. It may not be necessary to review the content of the document with the patient or those close to them, if sufficient information has been communicated. This will be a matter of clinical judgement for the healthcare professional with overall clinical responsibility for the patient and other members of the healthcare team.

The outcome of the review should be recorded on a ReSPECT form (either by completing a new form or endorsing section 9 on the existing ReSPECT form). This MUST be completed before transfer from the admitting clinical area.

Any old forms must be clearly cancelled and filed at the back of the medical notes.

Any patient attending the Trust with an active DNACPR pro forma from the Yorkshire Region or beyond should have this decision reviewed on admission. If a patient with a reviewed DNACPR pro forma has a cardiac arrest this will be honoured. The transfer of this decision to a ReSPECT form should be made as soon as practically possible.

5.16. Patients with Planned Frequent Readmission for Treatment with a ReSPECT Recommendation, e.g. IV Medication/Blood Transfusion

Patients receiving regular day case admission for treatment may be exempt from a clinical review of ReSPECT on each admission unless there are clinical changes or the patient wishes to re-discuss.

Give the original ReSPECT form to the patient when discharged to take with them.

If the patient has an acute admission the recommendation must be reviewed by the admitting physician and, if appropriate, endorsed or a new form completed.

6. TRAINING AND SUPPORT

ReSPECT will be covered in all Immediate Life Support training delivered by the Resuscitation Officer.

All staff involved with the ReSPECT process should complete the ReSPECT e-learning training package on the e-learning system.

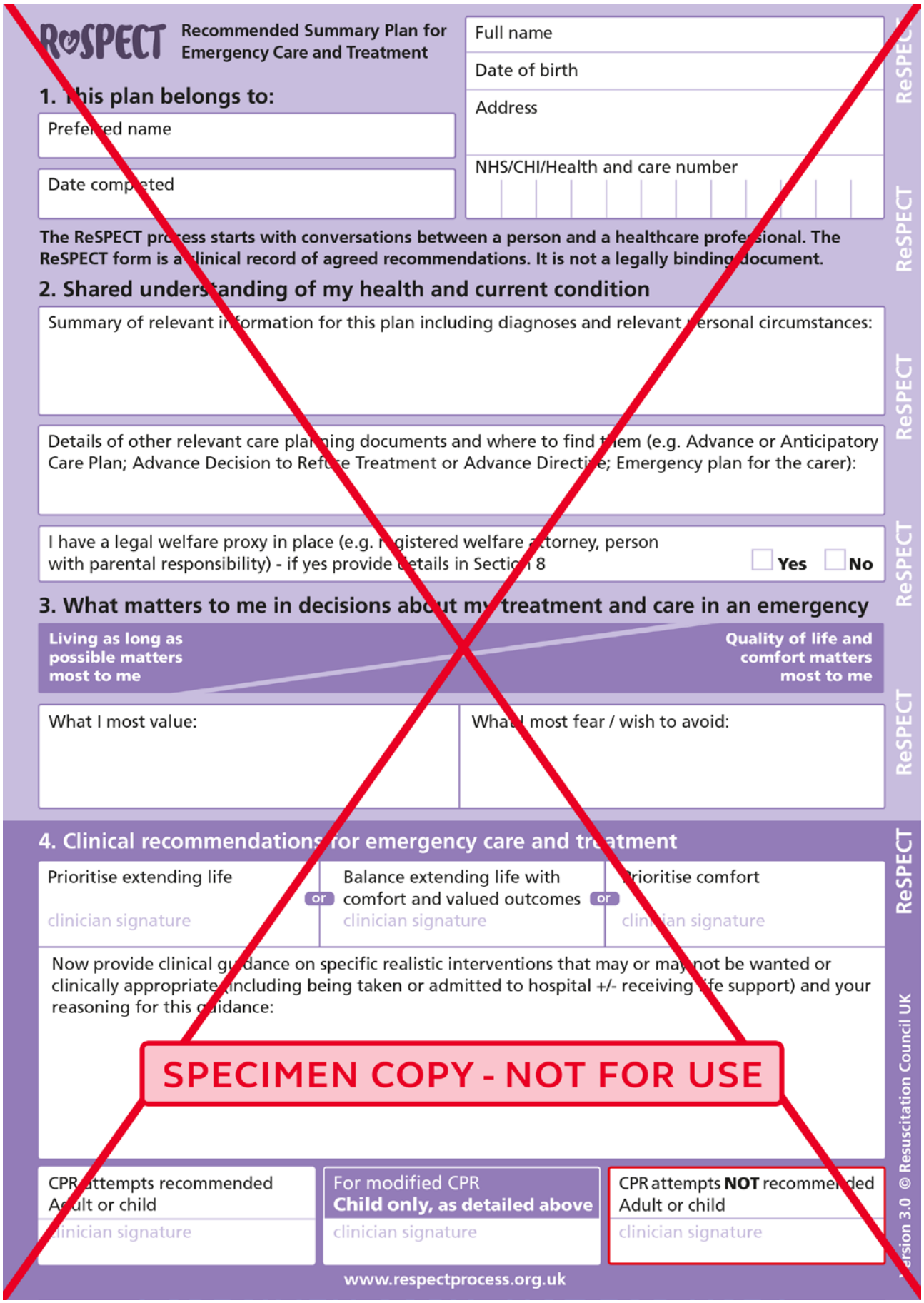
Staff who require training on Mental Capacity and Consent can access via training diary.

7. REFERENCE TO ANY SUPPORTING DOCUMENTS

- Mental Capacity Act and Best Interests Decision Making Policy
- Mental Health Act Policy
- Consent Policy
- Fritz ZB, Barclay SI. Patients' resuscitation preferences in context: lessons from POLST. Resuscitation 2014; 85:444-5. Perkins GD, Griffiths F, Slowther AM, et al. *Do-not-attempt- cardiopulmonary-resuscitation decisions: an evidence synthesis*. Health Services and Delivery Research, 2016
- Decisions Relating to Cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 1999. www.resus.org.uk

- Resuscitation guidelines 2015. London: Resuscitation Council (UK), 2015, Resuscitation Council (UK) Tavistock House North, Tavistock Square, London WC1H 9HRTelephone: 020 7388 4678, Fax: 020 7383 0773 Enquiries@resus.org.uk, www.resus.org.uk
- ReSPECT www.respectprocess.org.uk
- Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period 2009. http://www.aagbi.org/publications/guidelines/docs/dnar_09.pdf
- Mental Capacity Act (2005). Department of Health
- The Human Rights Act 1998. Equality and Human Rights commission. UK
- R (Tracey) v Cambridge University Hospital NHS Foundation (2012) UK

Appendix 1: Recommended Summary Plan for Emergency Care and Treatment



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name

Date of birth

Address

NHS/CHI/Health and care number

1. This plan belongs to:

Preferred name

Date completed

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me

Quality of life and comfort matters most to me

What I most value:

What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life

clinician signature

or

Balance extending life with comfort and valued outcomes

clinician signature

or

Prioritise comfort

clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

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

www.respectprocess.org.uk

ReSPECT

Version 3.0 © Resuscitation Council UK

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? ☐ Yes ☐ No Document the full capacity assessment in the clinical record.	If no, in what way does this person lack capacity? If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

SPECIMEN COPY - NOT FOR USE

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**

www.respectprocess.org.uk

Appendix 2: Generic ReSPECT Flowchart

Making a ReSPECT Decision

- **In the case of young people refer to appropriate section of policy for guidance on specific procedure**
- This decision should only be made after appropriate discussion with the patient and members of the healthcare team. It should be based purely upon clinical grounds. Have the patient's wishes and preferences been taken into consideration within the ReSPECT? This may include resuscitation status.
- Subjective views of quality of life, disability, or the patient's age must not be a factor in the decision-making process.

↓

Does the patient have mental capacity to make a ReSPECT decision?

↓ ↓

Yes – Patient has mental capacity	No – Patient lacks mental capacity
• If the patient has mental capacity and makes it clear to their consultant or a senior registered professional that they do not wish to be resuscitated, this view must be respected, and documented on a ReSPECT form. • If the healthcare team receive a valid advanced directive, or "living will", covering this eventuality, this should be documented clearly on the ReSPECT form. • Notifying the patient's family/friends of the patient's ReSPECT plan will require the patient's consent.	• If the patient lacks mental capacity, relatives or close friends will be valuable in voicing the patient's wishes when planning the ReSPECT. • Evidence must be provided of the lack of capacity assessment relating to the ReSPECT by completing a Mental Capacity Assessment Record (MCAR) found on the Trust intranet Mental Health site. • The MCAR must be filed in the patient's notes. • A Lasting Power of Attorney (health) or other legal proxy must be involved in the discussion on behalf of the patient in regards to their ReSPECT. • If the patient has no family or friends and a best interests decision has to be made, an Independent Mental Capacity Advocate (IMCA) should be consulted.

↓ ↓

Completion of the RESPECT Form

- The rationale for reaching any decision (and discussions had in relation to the decision) must be fully documented in the patient's notes and on the pro forma. Please see Appendix 1.
- The fully completed ReSPECT form must be filed in the front of the patient's notes.
- The person completing the ReSPECT form is responsible for ensuring this has been recorded on Lorenzo under the Advance Directive section.
- **Where a ReSPECT involves a young person inform the Medical and Nursing Directors ASAP**

ReSPECT and Decision Review

The ReSPECT and any DNACPR decision must be reviewed and documented in the medical notes whenever there is a clinical improvement; transfer of medical responsibility and on readmission, and if the patient requests this.

Patient Request	Clinical Change	Transfer of Medical Responsibility	Readmission
• If the patient wants to make a ReSPECT decision. • If the patient changes their mind about their existing ReSPECT decision.	• If the patient's condition has improved sufficiently to make the ReSPECT and DNACPR decision inappropriate. • In some circumstances it may be inappropriate for the ReSPECT to be reviewed, for example patients at the end of life.	• Where there is a transfer of medical responsibility within the hospital setting, the patient's ReSPECT form should be reviewed by the consultant accepting the patient. • When a patient is discharged into the care of their GP, the IDS should clearly state where there is a ReSPECT in place. • When discharged with a ReSPECT incorporating a DNACPR decision, the original form is given to the patient.	• If a patient is re-admitted with a completed ReSPECT form, this must be reviewed immediately and either cancelled, or decision confirmed in the review section on the ReSPECT form. • If the original form is not available on readmission a new ReSPECT form and decision process must be undertaken. • If a patient is admitted with a DNACPR form, a ReSPECT form should be completed as soon as practicable. In the event the patient has a cardiac arrest before a ReSPECT form has been completed, the DNACPR decision should be honoured.

Appendix 3: How to Complete a ReSPECT Form

Resuscitation Council UK

ReSPECT

The ReSPECT process - A guide for clinicians completing the form

Before you start:

- Remember that completing the form is only part of the ReSPECT process.
- You can use the sequence of sections on the form to guide you through the conversation that is an essential part of that process.
- Do **not** complete the form without maximum possible involvement of the person in the process (or of those best able to speak for them if they do not have capacity for involvement).
- Use the form to summarise what was discussed and agreed. Document more detailed information in the person's health record.

Section 1: "This plan belongs to"

Complete all details fully and clearly. Those responding to a future emergency must be able to identify the person immediately and confidently.

Section 2: "Shared understanding of my health and current condition"

Discuss, explain and achieve a shared understanding of the person's relevant health conditions and how these may progress or change. Summarise in this section's three boxes:

- Relevant conditions and circumstances. Do not record unnecessary detail (e.g. of past medical history, medication). Include communication problems and how to overcome them. Make sure that the person (or anyone speaking for them) knows and agrees with what you record.
- Specific detail of any other planning documents and where to find them.
- Whether or not they have a legal proxy. If so, put name and contact details in section 8.

Section 3: "What matters to me in decisions about my treatment and care in an emergency"

- Summarise what the person says would matter most to them (values and fears), both in daily life and as an outcome of future emergency treatment. If possible, use their own words. If the person does not have capacity to participate, whenever possible family or other representatives must be involved in establishing the person's likely wishes.
- Use the scale in section 3 to help the person understand how some people want all possible interventions to try to live as long as possible, others want care to focus only on maintaining their comfort and many want a balance between these. If they want to, the person can mark the scale to show their current wish; do not pressurise them to do this.
- Explain that this plan is for use only when they cannot make decisions about emergency care and treatment. If they can make decisions, they can make choices at the time.

Section 4: "Clinical recommendations for emergency care and treatment"

Record recommendations for a future emergency on interventions that:

- could result in desired outcomes and would be wanted
- are likely to result in a feared outcome and would not be wanted
- have little or no realistic chance of success, so would not work.

Following from clinical understanding and the values and fears agreed in sections 2 and 3, establish an agreed overall goal of care, and sign one of the three boxes:

- **Prioritise extending life:** They would receive treatment to control symptoms, and would want potentially life-sustaining treatments, even if they involve some discomfort and/or risk.
- **Balance extending life with comfort and valued outcomes:** They would want some potentially life-sustaining treatments in some circumstances.
- **Prioritise comfort:** They want care and treatment to control symptoms and maintain their comfort. This does not mean that they should not receive (for example) an antibiotic for an infection. They would not want invasive intervention with a primary purpose of extending life.

Next, record freehand clinical recommendations on **specific interventions** that would or would not be wanted or clinically appropriate, and summarise the reason for these. This may include whether the person would want to be taken to hospital and in what circumstances. Include other relevant recommendations (e.g. whether they should be considered for intensive care, or for 'invasive' ventilation). Complete this box clearly. Avoid jargon; use wording that will be easily understood by all who may respond to an emergency in any health or care setting.

ReSPECT guide for clinicians | updated March 2021 Page 1 of 2

Now, after discussion and agreement, sign in **ONE** of the boxes to indicate whether CPR attempts are recommended (or, in a child, whether a plan for modified CPR has been agreed).
A recommendation about CPR should be discussed within the discussion of overall goals of care, along with an honest explanation of what treatments can realistically be expected to achieve those goals. Remember that clinicians **must** discuss a recommendation not to attempt CPR with the person concerned, unless it is thought that it will cause physiological or psychological harm; if you believe this is so, you must document your reasons in section 6 and in the person's health record.

Section 5: "Capacity for involvement in making this plan"

- Assume the person has capacity.
- If you suspect the person has an impairment or disturbance of mind or brain, you must test their capacity for each specific decision. If the person lacks capacity for a specific decision, or they cannot have capacity (e.g. they are unconscious), the decision must be made by following the requirements of capacity legislation.

Section 6: "Involvement in making this plan"

Select **A, B** or **C** as appropriate, or complete section **D**. Select **D** – if there has been:

- no involvement of the person (adult with capacity or child with sufficient maturity and understanding) because you believe it would cause physiological or psychological harm
- no involvement of family or other representatives of a person who lacks capacity, because you believe this impracticable or inappropriate (e.g. no contact details or you believe that contacting a frail family member in the middle of the night would place them at risk)
- no involvement of those with parental responsibility for a child.

Summarise your reasons here; document them fully in the clinical record, together with a clearly defined plan to involve the person and/or their representatives as soon as possible/appropriate.

Section 7: "Clinicians' signatures"

As the professional who completed the ReSPECT form, you must sign this section and record the date and time. If you are not the senior responsible clinician, inform them of the plan and – at the earliest practicable time – they should review and endorse it by signing the shaded line (or – if appropriate – undertake further discussion and revision of the plan before signing it).

Section 8: "Emergency contacts and those involved in discussing this plan"

- If they want to, let the person and/or those close to them confirm their involvement by signing here.
- Their signatures are optional. They do not make the plan any more or less valid, or legally binding.
- Record details of people to be contacted in an emergency. Remember that the form is for use across all health and care settings.

Section 9: Form reviewed (e.g. for change of care setting) and remains relevant

- Leave this blank at initial plan completion.
- Review may be prompted by a request from the person or their representative, by a change in their condition or by their transfer from one care setting to another. The responsible clinician should review the ReSPECT form entries, and discuss the plan with the person themselves, unless to do so is justifiably unnecessary or would be harmful to them. If the recommendations are still appropriate, they should sign and date Section 9 to confirm this.
- If the recommendations are (or may be) no longer correct, they should be discussed and reviewed with the person (or representative(s) of a person who lacks capacity) and – where appropriate – a new ReSPECT form should be completed.

Appendix 4: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	DNACPR Policy and procedure including ReSPECT guidelines and procedure		
Document Purpose	This policy addresses the issues relating to the care of patients aged 12 and over. All staff employed by Humber Teaching NHS Foundation Trust are expected to comply with this policy. Independent primary care contractors are expected to comply with legislation, abide by the principles of this policy and support its implementation. This policy applies to all patients, aged 12 and over, in whom DNACPR and/or ReSPECT decisions are being considered. For all those at risk of deterioration or cardiac arrest or who want to have their wishes documented, a conversation regarding treatment options and focus of care should be held and a ReSPECT form should be completed. The aim of the ReSPECT process is to protect patients and support staff in making complex recommendations and to ensure all decisions/discussions are clearly recorded.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	June 2022	Physical Health and Medical Devices Group	
	June 2022	CAMHS Clinical Network	
	July-2022	Quality and Patient Safety Group (approved)	
Approving Committee: V4.0	Quality Committee	Date of Approval:	March 2018
Ratified at:	Trust Board	Date of Ratification:	March 2018
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Familiarisation for staff during BLS ILS has been happening and will continue. Stand- alone E-learning module for staff to complete.	Financial Resource Impact	None
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	This policy will be disseminated by the method described in the Document Control Policy. Implementation of this policy will be overseen by the Physical Health and Medical Devices Group which is a subgroup of Trust's Quality and Patient Safety Group.		
Monitoring and Compliance:	ReSPECT will be audited by the Resuscitation Officer on a yearly basis. The results will be fed back to the Physical Health and Deteriorating Patient group. Generalised learning will be disseminated as required. The Resuscitation Officer will undertake additional spot check audits as required.		

Document Change History:			
Version Number/ Name of procedural document this supersedes	*Type of Change, i.e. Review/Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
3.00	*Major changes*	*March 2014*	*Major changes to policy as now using joint policy.*
3.01	*Reformat*	*July 2014*	*Put into HFT format*
3.02	*Review*	*April 2016*	*Reviewed no changes required*

3.03	*Review*	*March 2017*	*Reviewed no major changes and updated with latest references to support practice.*
4.00	*New Policy*	*March 2018*	*New DNACPR/ReSPECT policy* *Approved at Quality Committee 2 May 2018 and ratified at Trust Board May 2018*
4.01	*Review and reformat*	*June 2019*	*Addition of principles children and young people, principles for patient with learning disabilities and principles for non-discriminatory decision making Apply new policy format* *Approved QPaS 21 August 2019*
4.02	*Review*	*June 2022*	*Addition of version 3 of ReSPECT form and Guide for completion.* *Approved PHMD June 2022 and QPaS 13-July-22*

Appendix 5: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy and Procedure including Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Guidelines and Procedure**
2. EIA Reviewer (name, job title, base and contact details): **John Sands**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy and Procedure**

Main Aims of the Document, Process or Service
This policy applies to all patients in whom DNACPR and/or ReSPECT decisions are being considered. For all those at risk of deterioration or cardiac arrest or who want to have their wishes documented, a conversation regarding treatment options and focus of care should be held and a DNACPR and/or ReSPECT form should be completed. The aim of the DNACPR/ReSPECT process is to protect patients and support staff in making complex recommendations and to ensure all decisions/discussions are clearly recorded.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment		

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Medium	Decisions must not be made on the basis of assumptions based solely on factors such as the person's age. When considering if the patient has sufficient maturity and understanding to participate in making the ReSPECT plan, the principles set out in the Consent Policy must be followed
Disability	Where the impairment has a substantial and long-term adverse effect on the ability of the person to carry out their day-to-day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	The terms "learning disability" and "down syndrome" should never be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause of death on part I of the Medical certificate Cause of Death.

			Decisions must not be made on the basis of assumptions based solely on factors such as the disability, or on a professional's subjective view of a person's quality of life. Such decisions are unethical and, in some cases, unlawful.
Sex	Men/Male Women/Female	Low	
Marriage/Civil Partnership		Low	
Pregnancy/ Maternity		Low	
Race	Colour Nationality Ethnic/national origins	Low	
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Medium	Jehovah's Witness beliefs around blood transfusions should be considered.
Sexual Orientation	Lesbian Gay Men Bisexual	Low	
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	

Summary

Please describe the main points/actions arising from your assessment that supports your decision. None.	
EIA Reviewer: ***Sadie Milner, Quality Standards Practice Development Nurse***	
Date completed ***13 July 2022***	Signature: ***S Milner***