ReSPECT NHS

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

Unified Adult ReSPECT Policy

Policy template for use across all providers in Herefordshire & Worcestershire

Version Control Record

Document Type	ICS Policy template for use across all providers
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In partnership with:
Herefordshire & Worcestershire CCG
Worcestershire Acute Hospitals NHS Trust
Herefordshire & Worcestershire Health and Care NHS Trust
Worcestershire County Council
Practice Plus
St Richards Hospice
Primrose Hospice
West Midlands Ambulance Service University NHS Foundation Trust
Kemp Hospice
Wye Valley NHS Trust
Herefordshire County Council
St Michael's Hospice
Taurus Healthcare Ltd

Herefordshire & Worcestershire NHS – ReSPECT Policy Summary

This policy:

Applies to people over 18 years of age, under the care of Herefordshire & Worcestershire NHS and VCS organisations and / or Social Care Services

Summary points

- The ReSPECT form acts as a summary document for any key information that could influence emergency care at a time when a patient may not be able to express their wishes. This policy template refers to decisions about a range of emergency care and treatment options. Such life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, and admission to ICU for intubation and ventilator support, inotropic and other cardiovascular support, as well as CPR.
- Advance decision making about care and medical treatment is a collaboration between a person, their family and their healthcare professionals. In an emergency situation, it is vital that healthcare professionals have a clear understanding of any identified limitations in an individual's treatment (such as to withhold cardiopulmonary resuscitation [i.e.: DNACPR order]).
- All significant treatment limitations must be clearly recorded on the ReSPECT form. This could include preferences about Critical Care admission, drug or other treatments – it is not limited to resuscitation decisions. **A ReSPECT form may NOT MEAN DNACPR**
- **ReSPECT is not a legally binding document.** The ReSPECT form should be regarded as a summary of an advance clinical assessment with recommendations, recorded to guide immediate clinical decision-making in the event of a person's physical health deterioration or cardiorespiratory arrest. It constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'advance decision to refuse treatment'. The final decision regarding whether or not to attempt CPR or other life-sustaining treatment rests with the healthcare professionals responsible for the person's immediate care.
- A ReSPECT form supplements additional detailed advance care planning documentation, such as the AMBER Care Bundle (Uncertain Recovery Plan) or ADRT documents – it does not replace them.
- It is the responsibility of the most senior registered healthcare professional in charge of a person's care, to review and endorse a completed ReSPECT form at the earliest opportunity following completion.
- Decisions to limit treatment must be discussed with the individual unless to do so would cause harm. Such decisions should also be discussed with those close to the person unless the person has indicated that this should not happen. Details of these conversations must be recorded.
- Only original ReSPECT forms are valid – never photocopy a ReSPECT form for clinical use. Refer to your organisations ReSPECT Standard Operating procedure for detail on version control.
- **Healthcare providers, who are <u>uncertain</u> about the need to give life-saving care, should always presume to save life**. Emergency care should be given until any previously agreed limitations are clearly understood – this clarity is the purpose of the ReSPECT form.
- ReSPECT forms must be reviewed when a person's condition or wishes significantly changes, or when they are transferred / admitted / discharged from one healthcare provider to another.
- ReSPECT forms must stay with the individual so that healthcare providers can easily access them. They should, where available, be available on the patient's digital record.

Accessibility

Interpreting and Translation services are provided for Herefordshire & Worcestershire NHS services including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting.

Please refer to the appropriate organisations intranet page: for full details of the service, how to book and associated costs.

Training and Development

Herefordshire & Worcestershire service providers recognise the importance of ensuring that its workforce has every opportunity to access relevant training. They are committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by stakeholder organisations are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

Co-production – Statement of Intent

Organisations expect that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with a person and/or their carers/representative, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths. It is important that patients are offered information on the treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

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1. Scope of Policy

This policy template has been ratified by the Worcestershire Acute Hospitals NHS Trust (WAHT) and the Herefordshire & Worcestershire Health and Care NHS Trust (HWHCT). It is also supported by the following organisations;

- West Midlands Ambulance Service University NHS Foundation Trust (WMASUFT)
- Herefordshire & Worcestershire CCG on behalf of Primary Care
- Practice Plus
- St Richards Hospice
- Primrose Hospice
- Kemp Hospice
- Worcestershire County Council on behalf of social care/ residential/care homes & domiciliary care
- Herefordshire Council on behalf of social care/ residential/ nursing homes & domiciliary care
- Wye Valley NHS Trust
- Taurus Healthcare Ltd
- St Michael's Hospice

It therefore applies to all staff in these organisations and can be used across the whole of Herefordshire & Worcestershire NHS as a template.

1.1. This guidance applies to adults aged 18 and over. There is no additional ReSPECT policy for children however children may have a ReSPECT form. For people under the age of 18, refer to the Advance Care Plan for a Child or Young Person, West Midlands Paediatric Palliative Care Network. (www.cypacp.uk)

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

1.3. This policy has been written with reference to the latest guidance issued by the British Medical Association (BMA) / Royal College Nursing (RCN) / Resuscitation Council and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK). (http://www.resus.org.uk/pages/dnar.htm).

2. Aims of policy

2.1. To set out the principles which govern the use of the Recommended Summary Plans for Emergency Care and Treatment (ReSPECT).

2.2. To ensure that any decisions relating to a person's care and treatment, including Do Not Attempt CPR, are made with the person, or their representative, and are appropriate to the circumstance and include any limitations, with reference to:

- the use of current national guidelines (Appendix One).
- compliance with the Mental Capacity Act 2005 as detailed in the national guidelines.
- Clear documentation on the ReSPECT summary form (Appendix Two).
- Communication to all health and social care professionals involved in a person's care.
- Appropriate reviews.

3. ReSPECT Principles

3.1. ReSPECT stands for **Re**commended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment. It is a widely used process and is recognised nationally. People in Herefordshire & Worcestershire will be able to transition from one care setting to another with all professionals recognising and endorsing ReSPECT.

3.2. The ReSPECT process creates a summary of personalised recommendations for clinical care in a future emergency, including cardiac arrest, in which they do not have capacity to make or express choices. The process is intended to respect both individual preferences and clinical judgement. The agreed clinical recommendations that are recorded should include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

3.3. ReSPECT aims to promote more conversations between people (and or their families) with clinicians, leading to shared decision making (when possible), better advanced planning, good communication and documentation and better overall care.

3.4. For many people, anticipatory decisions about emergency care and treatment, including CPR, are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

3.5. ReSPECT should be considered for those people who are at risk of a clinical deterioration that may place their life at risk. These people may already have an existing life limiting illness, such as advanced organ failure, or cancer.

3.6. The primary goal of healthcare is to benefit people, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the person, or if an adult with capacity has refused treatment, and documented accordingly when necessary, then that treatment is no longer justified (BMA, RC (UK) RCN 2007). Even potentially life-saving treatment can be withheld or withdrawn if it is not in the person's best interests and they lack capacity to make that decision at that time.

3.7. Cardiopulmonary resuscitation (CPR) is one treatment that has received much attention, and that has undoubted potential benefits for some people. However, CPR is often physically damaging (e.g. breaking ribs) and for many people there

will be minimal or no chance of success, offering little or no benefit to the person receiving it. A person 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 in their situation.

3.8. Evidence suggests that when discussions have taken place about CPR in the context of overall goals of care; there is a reduction in the incidences of harm compared to focusing only on 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions and where harm does occur it is less severe.

3.9. 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'. 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.

3.10. Several factors are important to consider when these decisions are made. These include the chances of the treatment in question being successful and the likelihood of it being offered, 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 who have been appointed to act on the person's behalf.

3.11. Documented evidence of a person's choices 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 significant situation where a person lacks mental capacity to make or contribute to making decisions at that time. Knowing what a person would have wanted keeps them at the centre of care, even when they may not be able to make their wishes known.

3.12. ReSPECT is not a legally binding document. The ReSPECT form should be regarded as a summary of an advance clinical assessment with recommendations, recorded to guide immediate clinical decision-making in the event of a person's deterioration or cardiorespiratory arrest. It constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'advance decision to refuse treatment'. The final decision regarding whether or not to attempt CPR or other life-sustaining treatment rests with the healthcare professionals responsible for the person's immediate care.

3.13. Decisions documented on a ReSPECT form **do not** override clinical judgement. In the unlikely event of a reversible cause of the person's deterioration that does not match the circumstances envisaged when those decisions were made and recorded then the ReSPECT form may be overridden. Examples may include choking, a displaced tracheal tube or a blocked tracheostomy tube, anaphylaxis, and other unforeseen and potentially reversible causes.

3.14. An Advance Decision to Refuse Treatment (ADRT) is the only legally binding form of documentation in relation to the cessation of treatment for a patient. If the

individual has one of these it should be referenced on the ReSPECT form.

4. What is a ReSPECT conversation?

4.1. The emergency care summary plan is created through conversations between a person and one or more of the health professionals who are involved with their care. Involvement of those who are important to a person (e.g. family, carer, legal welfare proxy) should be offered and encouraged with the persons consent.

4.2. A ReSPECT conversation follows the ReSPECT process by:

- Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future
- Identifying the person's preferences for and goals of care in the event of a future emergency
- Using this information to record an agreed focus of care as being more towards life-sustaining treatments or more towards prioritising comfort rather than efforts to sustain life
- Making and recording shared decisions about specific types of care and realistic treatment that the person would want considered, or that they would not want, and explaining sensitively advance decisions about treatments that clearly would not be successful in their situation
- Making and recording a shared decision about whether or not CPR is recommended

4.3 The plan should **stay with the person** and be available immediately to health and care professionals faced with making immediate decisions in an emergency in which the person has lost capacity to participate in making those decisions.

4.4 Advance decisions must be made on the basis of an individual patient assessment and in consultation with the person, save in the exceptional circumstance that consultation is likely to cause physical or psychological harm to that person. The reason(s) not to consult with the person must be recorded in the patient record.

4.5 ReSPECT may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, an education setting, a hospice or a hospital. Professionals such as ambulance crews, out-of-hours doctors, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to an agreed plan and clinical recommendations on a ReSPECT form.

5. To whom does this policy apply?

5.1 This policy applies to all adults in whom advance decisions relating to both physical and mental healthcare are being considered.

5.2 This policy is intended for all adults, however below is a list (although not exhaustive) where a ReSPECT conversation and form may have more relevance;

- with particular health needs that may involve a sudden physical deterioration in their health

- with a life limiting condition, such as advanced organ failure, advanced cancer or frailty
- who are likely to be nearing the end of their lives
- at risk of sudden events, such as epilepsy or diabetic crisis
- at foreseeable risk of death or sudden cardiorespiratory arrest
- who want to complete the ReSPECT process and documentation for other reasons.

5.3. Considering explicitly, and whenever possible making specific anticipatory decisions about, emergency care and treatment options, including CPR, is an important part of good quality care for any person who is approaching the end of life and/or is at risk of further deterioration and cardiorespiratory arrest

5.4. If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with the person for whom the ReSPECT form is being completed. However, they may still wish to discuss other aspects of emergency care and treatment, so then a ReSPECT conversation may be appropriate.

5.5. This policy refers to decisions about a range of emergency care and treatment options. Such life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, and admission to an Intensive Care Unit (ICU) for intubation and ventilator support, inotropic and other cardiovascular support, as well as CPR.

5.6. This policy applies to all of the multidisciplinary healthcare team involved in the individual's care.

6. Cardiopulmonary resuscitation

6.1 For many years there has been debate over the use and design of DNACPR forms, together with recognition of their limitations. The ReSPECT process was created following a systematic review of DNACPR decisions and documents. An approach that focuses only on withholding CPR in people who are dying or for whom CPR would offer no overall benefit has resulted in misunderstandings, poor or absent communication, particularly with individuals or their family, and poor or absent documentation. ReSPECT aims to encourage patient and family involvement in decision-making, to consider recommendations about CPR in the context of broader plans for emergency care and treatment, and to record the resulting recommendations on a form that would be used and recognized by health and care professionals across the country.

6.2 CPR could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically CPR could be used on every individual prior to death. There will be some cases where attempted resuscitation following cardio-respiratory arrest will not be effective. There will also be some cases where attempted resuscitation following cardio-respiratory arrest is not in the person's best interests because the potential burdens are likely to outweigh any possible benefits. It is essential to identify people for whom cardiopulmonary arrest represents the terminal event in their

illness, and for whom CPR is therefore inappropriate.

6.3 Making a decision not to attempt CPR or other life-sustaining treatment that has no realistic prospect of success does not require the consent of the individual or of those close to them. However, there is a presumption in favour of informing a person of such decisions. The individual and those close to them have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate but wherever possible it is better to have discussed the options with the patient.

6.4 Failure to make timely and appropriate decisions about life-sustaining treatment may leave people at risk of receiving inappropriate or unwanted attempts at CPR and other active treatments as they die. The resulting indignity, with no prospect of benefit, is not acceptable, especially when many would not have wanted such treatment had their needs and wishes been explored.

6.5 Do Not Attempt CPR (DNACPR) recommendations relate only to the act of CPR (e.g. chest compressions, ventilations, and defibrillation) and do not in themselves place any limitations on other aspects of the person's care. The ReSPECT process encourages clinicians to explore other treatments and interventions and the goals of care with the person rather than make decisions about CPR in isolation.

6.6 A DNACPR decision must be communicated to the individual and / or relatives (with the consent of the individual if appropriate) unless the clinician feels the person will suffer *harm* by doing so. The fact that a person may find the topic distressing is not a reason to make it inappropriate to involve them. A persons involvement in a plan must be recorded on the form clearly and reasons detailed if no involvement.

6.7 It may be against the clearly stated wishes of the individual to attempt cardiopulmonary resuscitation (CPR). Such cases should be clearly identified and health and social care staff involved in the person's care should be made aware of action to take in the event of cardio-respiratory arrest.

6.8 If a person with capacity refuses CPR and other life sustaining treatment, or a person lacking capacity has a valid and applicable Advance Decision Refusing Treatment (ADRT), specifically refusing a particular treatment, this must be respected. If a person has capacity but it is likely to decline, they should be encouraged to consider making an ADRT or appointing a Lasting Power of Attorney (LPA) to ensure their wishes are legally recorded and followed.

6.9 A "Do Not Attempt CPR" (DNACPR) decision only relates to attempting CPR and does not relate to any other on-going treatment or care that the individual is receiving or may need.

6.10 Every decision about CPR must be made on the basis of a careful assessment of each individual's situation.

6.11 DNACPR recommendations will no longer be recorded on separate

documentation; the recommendation will be recorded on a ReSPECT form as anticipatory recommendations about CPR are best made in the wider context of advance care planning. This is an important part of good quality care for any person who is approaching end of life and/or is at risk of cardiopulmonary arrest.

6.12 Existing and valid DNACPR decisions recorded on DNACPR documentation dated 30th June 2019 or before will remain valid, however a ReSPECT conversation must take place as soon as possible and the DNACPR recommendation reviewed and transferred onto the ReSPECT form. The old DNACPR form must then be cancelled, but should refer to the creation of a completed ReSPECT form to avoid confusion as to the person's DNACPR status, and filed in the patient health record.

6.13 All new DNACPR decisions from 1st July 2019 to be recorded on a ReSPECT form as part of a ReSPECT conversation.

6.14 Medical emergencies where a DNACPR decision is required in isolation: The resuscitation recommendation can be signed on the ReSPECT form and the reason for this recommendation in isolation recorded. A wider ReSPECT conversation with the individual or representative should be commenced as soon as reasonably practicable.

6.15 In most cases there should be a presumption in favour of attempting resuscitation unless a valid and applicable DNACPR decision has been made. However, in appropriate circumstances a decision not to start CPR will be supported.

6.16 DNACPR recommendations are only applicable when death will occur through natural causes. They are not intended to cover cases of attempted suicide.

6.17 Similarly, other life-sustaining treatments may be futile for those dying of a terminal condition, as they would not reverse the underlying cause of the decline. It may then be appropriate to consider making decisions to avoid CPR and other life-sustaining treatments, to ensure that when death occurs there is no added loss of dignity. It is also essential to identify those people who would not want such treatments to be attempted in the event of deterioration in their condition and who competently refuse these treatment options.

6.18 If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and that CPR or other life-sustaining treatment would not be effective, CPR should not be attempted.

6.19 A decision-making framework relating to CPR, based on the "Resuscitation Council UK (2016) Decisions relating to cardiopulmonary resuscitation" guidance, is included in Appendix 3.

7. ReSPECT in practice

7.1. Every decision about emergency care and treatment options must be made on the basis of a careful assessment of each individual's situation and wishes.

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

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

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

7.5. During such discussions, staff should explore treatment options and goals of care (e.g. referral to ICU, HDU, antibiotics and NEWS scoring etc.) which are relevant to the individual. Recommendations limiting other aspects of care must be clearly and explicitly recorded in the medical record and communicated to the multi- disciplinary team.

7.6. Clear and full documentation of decisions about life-sustaining treatment, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This will require documentation in the health record of detail beyond the content of a specific ReSPECT form.

7.7. For non-English speaking individuals and families, to ensure an informed decision can be arrived at, an interpreter will be required. It is **not** best practice to use relatives as interpreters. To obtain interpreters follow local procedures.

7.8. Peoples with Learning Disabilities, communication difficulties including speech, sight or hearing impairment should have facilities provided to ensure their understanding wherever possible.

7.9. ReSPECT recommendations should be recorded on the **nationally recognised form** (Appendix 2) which should be filed at the front of the medical notes while in hospital and should be kept somewhere accessible to all when the person is not 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 individual and any relevant others.

7.10. Both versions 2 and 3 of the nationally recognised form are accepted in Herefordshire and Worcestershire. The two counites operate using the paper process at present with an aspiration to move to the Shared Care Record digital ReSPECT in 2023/24. Until the integrated digital ReSPECT is available to all providers, the paper process **only** is accepted. All other templates should not be used.

7.11. ReSPECT forms must remain with the person. They must be reviewed upon discharge from a clinical setting and ensure the person is advised to keep the document in a safe and visible place that carers, family and friends are aware of to ensure this is accessible in the event of an emergency.

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

- Whenever significant changes occur in the person's condition
- If there is a change in the person's expressed wishes
- Whenever the person is admitted, discharged or transferred from one healthcare provider to another.

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

7.14. ReSPECT covers hospital and community care episodes, including all healthcare professionals within Herefordshire & Worcestershire.

7.15. Following transfer between healthcare settings, ReSPECT decisions remain valid but should be verified as soon as possible by the clinician with overall responsibility for the person's care. The ReSPECT form (Appendix 2) should be used and accepted by all providers across Herefordshire & Worcestershire.

7.16. It is possible that a person may have a DNACPR decision or other emergency care and treatment plan documented on a different form. For example, they may have been transferred from a different county/ country, an old version of the DNACPR form may have been used in error, or their DNACPR decision may have been documented in an Advance Decision to Refuse Treatment without an accompanying ReSPECT form. Unless there is a good reason to believe the decisions are not genuine or applicable, they should be accepted as valid until the decisions are reviewed by the person's responsible senior clinician and a ReSPECT conversation takes place and form completed. Please see Appendix 4 for specific guidance around the transfer of patients from/to Wales.

7.17. ReSPECT forms **must not** be photocopied – only original forms are valid. Urgent efforts should be made to obtain a known existing original form. In an emergency situation (such as cardiac arrest) and in the absence of an original form, the senior clinician should make a best interests judgement as if no form existed. Once the digital ReSPECT process via the Shared Care Record is live, there will be less importance on an original paper form; as the live and most up to date plan will be available for all clinicians to view. Please consult your organisations ReSPECT SOP for specific guidance relating to digital forms.

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

8. Clinical Responsibility for ReSPECT recommendations

8.1 Anyone involved in the care of the individual can initiate the process, where this seems to be likely to be helpful. It does not have to be the GP or the hospital doctor and may, for example, be a specialist nurse involved in the person's care. WMASUFT will be responding to, but not creating ReSPECT forms.

8.2 The most senior registered health care professorial currently in charge of the individual's care at the time the ReSPECT is made carries responsibility for that recommendation until the individual is formally transferred. Foundation year 1 doctors, in this context, should not be viewed as registered health care professionals as their registration is provisional.

8.3 The senior registered health care professional might include a suitably experienced senior nurse or registered health care professional. Such decisions should be made by the most senior member of the clinical team available and then endorsed by the Consultant/GP at the earliest possible opportunity.

8.4 The senior responsible clinician should be prepared to discuss the recommendation for the individual with other health professionals involved in their care, including the person's GP. This is particularly relevant when formulating ReSPECT for outpatients or those being discharged from hospital care.

8.5 Where a ReSPECT conversation has been undertaken and documented by any registered health care professional, such as a registered nurse, who does not have overall responsibility for the persons care, when the most senior registered health care professorial currently in charge of the person's care next reviews the individual they should review and sign to endorse the ReSPECT recommendations if in agreement or alternatively amend the plan following further discussion with the person.

8.6 Where no explicit decisions about CPR and other life-sustaining treatment have been considered and recorded in advance there should be an initial presumption in favour of active treatment.

8.7 There may also be occasions when due to unavoidable circumstances a registered nurse (or any member of health care staff) who is unable to contact a doctor immediately, makes a decision based on their knowledge of the person's condition, the person's circumstances and the person's wishes, not to commence resuscitation. The reasons for this decision must be fully documented. The ICB will support any appropriate decisions made in these circumstances.

8.8 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 in the patient record. Ultimately, the responsibility to complete the ReSPECT form rests with the most senior health care professional in charge of the person's care.

8.9 Where the clinical recommendation is challenged or an objection is raised about the ReSPECT by an individual, 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.

8.10 The healthcare professional completing the ReSPECT form should fill in their details and sign the form. The recommendation must be discussed and agreed with the senior clinician responsible for the person's care. This might be their GP,

hospital consultant or out of hours practitioner depending on the setting. The name of the responsible senior clinician the ReSPECT recommendations were discussed with should be clearly documented and their agreement confirmed.

8.11 Guidance for clinicians on how to complete the various sections of a ReSPECT form can be found in Appendix 2. Further information for individuals, families and members of the public, for young people, and for parents, can be found on the ReSPECT website at https://www.respectprocess.org.uk/.

9. Situations where there is a lack of agreement

9.1. A person with mental capacity may refuse any treatment from a doctor or nurse even if that refusal results in death and any treatment carried out against their wishes is technically an assault. In these circumstances, individuals should be encouraged to make an ADRT.

9.2. Should the person with capacity refuse CPR or any other form of life- sustaining treatment, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and any family members or others that they wish to be involved, has taken place.

9.3. A previous verbal request to decline CPR or other life-sustaining treatment should be considered when making a best interest decision once a person has lost capacity, even if this was not documented formally on a ReSPECT form or as part of an ADRT. The verbal request needs to have been documented in the person's case notes by the person who it is directed to and can be used to support clinical judgement.

9.4. Although individuals do not have a legal right to demand that doctors carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected wherever possible.

9.5. In the case of disagreement, a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought from the organisation's legal representatives.

10. Cancellation of emergency care and treatment decisions

10.1. If the person's clinical condition changes, the decision may be made to cancel or revoke the current ReSPECT form. If the form is cancelled, it must be crossed through with two diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional, who will print their name and GMC / NMC number clearly underneath their signature for purposes of validation.

10.2. The form should be immediately removed and filed in the correspondence section of the patient record. Cancelled ReSPECT forms must not be destroyed as they are an important record of discussions and decisions.

10.3. It is the responsibility of the healthcare professional cancelling the ReSPECT form

to communicate this to all relevant parties involved in the care of the individual.

10.4. Another conversation should take place with the person and/or their representatives, and a new ReSPECT form created where appropriate.

11. Temporary suspension of emergency care and treatment decisions

11.1. In some circumstances there are reversible causes of deterioration in a person's condition, including cardiorespiratory arrest. These are either pre-planned or acute and it may be appropriate for some or all of the ReSPECT decisions to be temporarily suspended under these circumstances.

11.2. Pre-planned: Some procedures could precipitate a deterioration or cardiopulmonary arrest, for example induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations. Under these circumstances the ReSPECT decisions should be reviewed prior to procedure and consideration made as to whether the decisions should be suspended. Discussion with key people including the individual and/or carer, if appropriate, will need to take place.

11.3. If a decision to temporarily suspend any aspect of the advance decision is agreed this should be recorded in full in the patient record, including the recommendation(s) suspended the reason for the suspension and the period of time to which it applies.

11.4. Where the person suffers an acute, unforeseen, but immediately life threatening situation such as anaphylaxis or choking, CPR or other emergency care and treatment would be appropriate for the reversible cause.

11.5. After the event, the ReSPECT decisions should be reviewed and discussed with the individual and reinstated where appropriate.

12. Capacity

12.1. Under the Mental Capacity Act (2005) clinicians are expected to understand how the Act works in practice and the implications for each individual for whom emergency care and treatment decisions, including DNACPR, have been made.

12.2. The following sections of the European Convention on Human Rights are relevant to this policy:

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14)

12.3. In addition this policy takes heed of, and is compliant with, Tracey v Cambridge University Hospitals NHS Foundation Trust 2014 and Winspear v City Hospitals Sunderland NHS Foundation Trust 2015.

12.4. Where individuals are detained under the Mental Health Act, the provisions of this Act only apply to decisions about mental health treatment for a mental health condition. Capacity legislation applies to all other decisions. Therefore, for individuals detained under the Mental Health Act decisions about any other aspect of care including CPR and other forms of life sustaining treatment should be made with regard to the Mental Capacity Act. Detention under the Mental Health Act would not nullify decisions documented on a ReSPECT form, ADRT or advance care plan written about non-psychiatric conditions.

12.5. If the person has capacity to take part in the making of the recommendations, they must be involved fully with the process of making them. Many people want to have the support of family, friends or carers in the discussion, and some may choose to have a family member or friend advise them on what decisions to make.

12.6. If the individual does not want their family or other carers to know about their condition or their decisions, they should make sure that the healthcare team knows about this so that their wishes for confidentiality can be respected.

12.7. If a person has capacity a DNACPR decision must be communicated to them unless the clinician feels the person will suffer harm if they are consulted – any rationale to this end must be clearly reasoned and documented. The fact that a person may find the topic distressing is not a reason to make it inappropriate to involve them.

12.8. If a person indicates that they do not wish to discuss emergency treatments and resuscitation, this instruction should be respected. Where a ReSPECT form is to be completed and there has been no discussion with the individual 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.

12.9. If a person lacks capacity to contribute to a decision about resuscitation, the assessment of capacity must be documented in their health records, and any decision must be made in the person's best interests, and must comply with the Mental Capacity Act 2005. The assessment and recording of capacity can be made using the appropriate local capacity forms such as MCA1 (record of mental capacity assessment) and MCA2 (record of actions taken to make a best interest decision) which are common across Worcestershire Safeguarding Adults Board (2017).

12.10. In situations where a person has no capacity and staff are unaware that a valid advance decision refusing CPR (which is relevant to their current condition) has been made, then a further check must be made to identify if the individual has appointed a legal welfare proxy or Court Appointed Deputy. These individuals have similar powers to those with Power of Attorney but are appointed for people who have never had capacity (those people with Mental Handicap rather than those people who lose capacity for reasons such as Dementia).

12.11. In situations where a person lacks capacity, there is no advance decision and no appointed welfare attorney, it is strongly recommended that contact be made with any family members, friends or other advocate with whom it is appropriate to consult. They may be able to help by indicating what the person would have decided if they were able to do so. However, they should not be made to feel responsible for the decision, which remains a medical decision.

12.12. In situations where the person lacks capacity, there is no advance decision, no welfare attorney appointment and no appropriate family, friends or other advocate to consult, then it is strongly recommended that a referral to the Independent Mental Capacity Advocate (IMCA) service be made. This however does not apply in the emergency situation where the person's death is imminent. For details of the IMCA service in Worcestershire: http://www.onside-advocacy.org.uk/what-we-do/IMCA.html

13. Organisations that agree to the principles of this policy template

- Worcestershire Acute Hospitals NHS Trust
- Herefordshire & Worcestershire Health and Care NHS Trust
- West Midlands Ambulance Service University NHS Foundation Trust.
- Herefordshire & Worcestershire CCG (inclusive of primary care)
- Worcestershire County Council
- Kemp Hospice
- St Richards Hospice
- Primrose Hospice
- Practice Plus
- Wye Valley NHS Trust
- Herefordshire Council
- St Michael's Hospice
- Herefordshire Taurus Healthcare

14. Guidance

14.1. Guidance has been developed by the Resuscitation Council (UK):

14.2. Recommending standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)

14.3. Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (October 2007, updated October 2014)

14.4. Decisions relating to Cardiopulmonary Resuscitation is available at https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/.

14.5. Further information about ReSPECT is available at https://www.respectprocess.org.uk/ Or https://www.hacw.nhs.uk/respect/

15. Glossary

Advance Care Plan (ACP)
An Advance Care Plan is a structured documented discussion with individuals and their families or carers about their wishes and thoughts for the future. It is a means of improving care for people, usually those nearing the end of life, and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. An ACP is likely to contain information about personal preferences (e.g. place of care preferences, funeral plans, understanding prognosis).

Capacity
Capacity means the ability to make and express a decision in relation to a particular matter. To have capacity a person must be able to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision and to communicate that decision (whether by talking, using sign language or any other means). If their mind is impaired or disturbed in some way, making and communicating decisions may not be possible. A person may lack capacity temporarily or permanently. However, a person should be assumed to have capacity for a decision unless or until it has been shown that they do not.

Cardiopulmonary Resuscitation (CPR)
Cardiopulmonary Resuscitation includes all the procedures, from basic first aid to advanced medical interventions, that can be used to try to restore the circulation and breathing in someone whose heart and breathing have stopped. The initial procedures usually include repeated, vigorous compression of the chest, and blowing air or oxygen into the lungs to try to achieve some circulation and breathing until an attempt can be made to restart the heart with an electric shock (defibrillation) or other intervention.

Children and Young People
In law, a child is anyone under the age of 18 years. Parental responsibility persists until a child is 18, but a child can attain competence to make decisions for themselves (Gillick competence) according to their age and maturity and, once they are 16 years old, are assumed to have capacity to make their own decisions like an adult. In this document the term “children and young people” is used to refer to anyone under the age of 18, but the law in this area is complex, particularly with regards to those who are 16 and 17.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Do Not Attempt Cardiopulmonary Resuscitation decisions have also been called DNR, DNAR or ‘Not for Resuscitation’ (NFR) decisions or ‘orders’. They refer to decisions made and recorded to recommend that CPR is not attempted on a person should they suffer cardiac arrest or die. The purpose of a DNACPR decision is to provide immediate guidance to health or care professionals that CPR would not be wanted by the person, or would not work or be of overall benefit to that person. This tries to ensure that a person who does not want CPR or would not benefit from it is not subjected to CPR and deprived of a dignified death or, worse still harmed by it.

Intensive Care Unit (ICU)
Intensive Care Unit is also referred to as Intensive Therapy Unit (ITU). This is the area in a hospital that provides sophisticated monitoring and equipment to assess and support the function of a critically ill individual’s vital organs, such as the lungs or kidneys or heart and

circulation (e.g. a ventilator to help with breathing) until, whenever possible, they recover.

Mental Capacity Act (MCA)
The Mental Capacity Act (MCA) is legislation designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
Recommended Summary Plan for Emergency Care and Treatment ReSPECT is the first nationwide approach to discussing and agreeing care and treatment recommendations to guide decision-making in the event of an emergency in which the person has lost capacity to make or express choices. This process can be used by people of all ages.

Resuscitation
Resuscitation is general term used to describe various emergency treatments to correct life-threatening physiological disorders in a critically ill person. For example, 'fluid resuscitation' is rapid delivery of fluid into the bloodstream of a person who is critically fluid-depleted. Rapid blood transfusion for someone with severe bleeding is another example. Cardiopulmonary resuscitation (CPR) is sometimes referred to as 'resuscitation' but is a specific type of emergency treatment that is used to try to restart the heart and breathing.

16. References

- Advance Decision to Refuse Treatment, a guide for health and social care professionals. London: Department of Health.

- British Medical Association, (2000). The impact of the Human Rights Act 1998 on medical decision-making. London, BMA Books.

- British Medical Association, (2001). Withholding or withdrawing life- prolonging medical treatment. 2nd ed. London, BMA Books.

- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland 2010.

- GMC Treatment and Care Towards the end of life: good practice in decision making 2010.

- Human Rights Act. (1998) London: Crown Copyright. www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1.

- Mental Capacity Act. (2005) London: Crown Copyright. www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1.

- ReSPECT: Recommended Summary Plan for Emergency Care and Treatment website available at https://www.respectprocess.org.uk.

- Resuscitation Council UK (2016) Decisions relating to cardiopulmonary resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the ‘Joint Statement’) 3rd edition (1st revision) https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/.

- The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): A policy to support its use. NHS London Strategic Clinical Networks April 2017.

- Tracey v Cambridge University Hospitals NHS Foundation Trust and others [2014] EWCA Civ 33.

- Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy NHS South Central 2010.

- Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB)

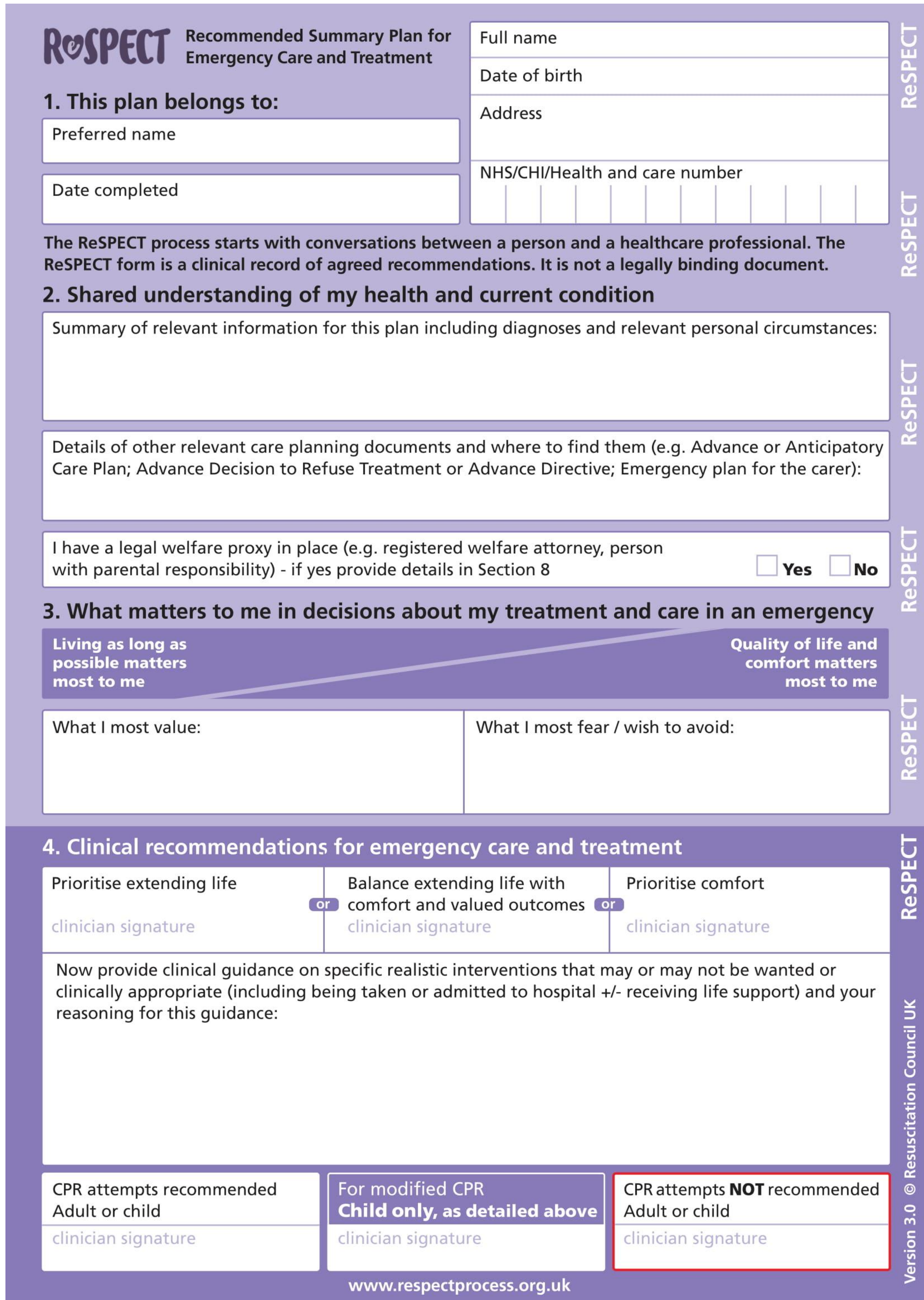
- A Clinical Policy For Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales. Revised Policy v4 – November 2020

Appendix 1 – Resuscitation Guidelines 2015

For the latest guidelines please follow:

https://www.resus.org.uk/resuscitation-guidelines/adult-basic-life-support-and-automated-external-defibrillation/
https://www.resus.org.uk/resuscitation-guidelines/adult-advanced-life-support/

Appendix 2 - ReSPECT form



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:

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

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ReSPECT ReSPECT ReSPECT ReSPECT ReSPECT ReSPECT

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? ☐ Yes ☐ No → If no, in what way does this person lack capacity?

Document the full capacity assessment in the clinical record.

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

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

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The ReSPECT process - A guide for clinicians completing the plan

Before you start:

- Remember that completing the plan is only part of the ReSPECT process.
- You can use the sequence of sections on the plan to guide you through the conversation that is an essential part of that process.
- Do **not** complete the plan 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 plan 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 what is important to the person.
- 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.
- Explain that this plan is for use only when they cannot express what is important to them about their emergency care and treatment.

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.

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 plan, 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).

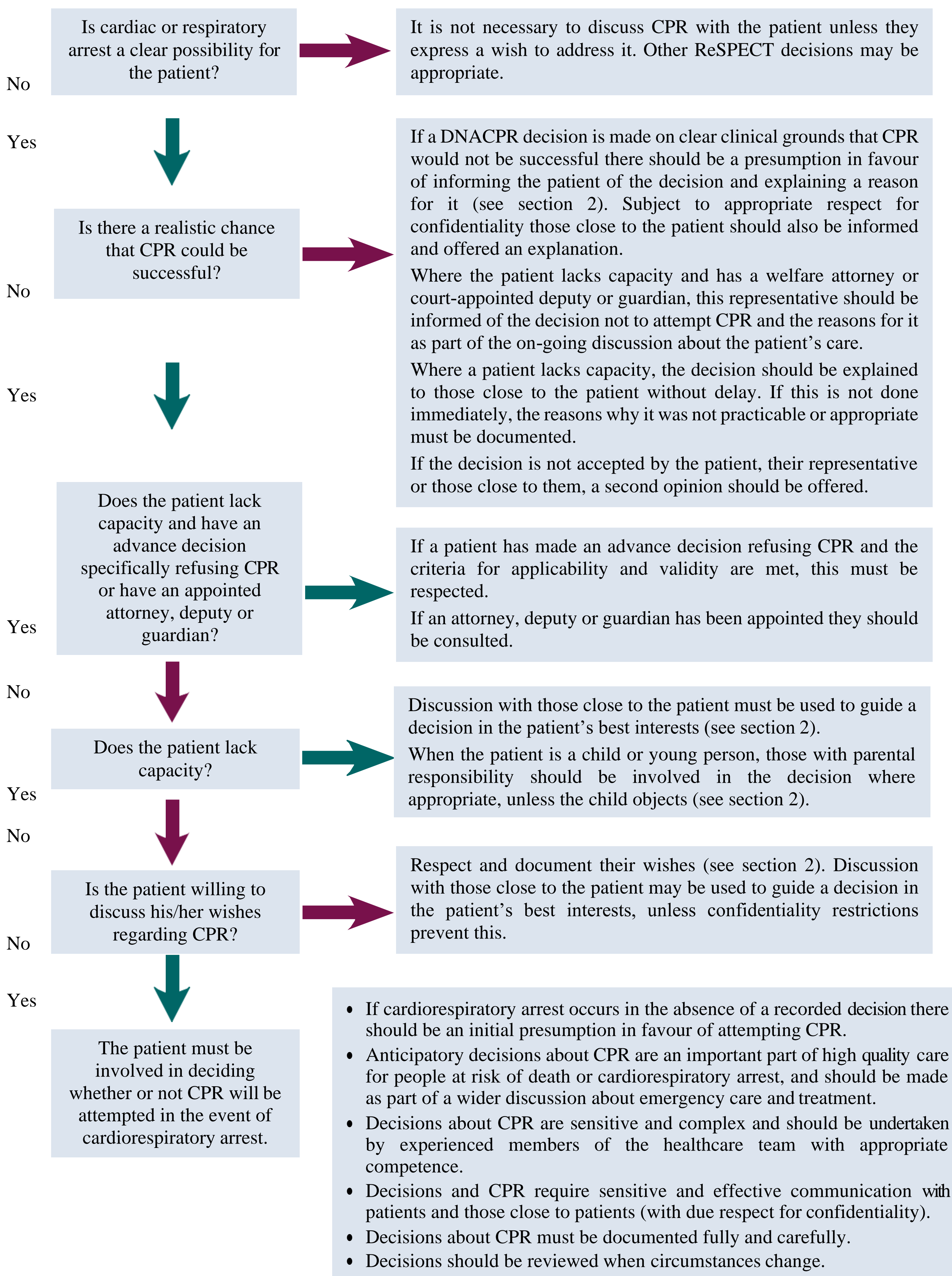
Section 8: "Emergency contacts and those involved in discussing this plan"

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 legally binding. Record details of people to be contacted in an emergency. Remember that the plan is for use across all health and care settings.

Section 9: Plan 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 plan 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 plan should be completed.

Appendix 3 – Decision-making framework for CPR



Appendix 4 – Specific guidance where care extends between two countries: Powys patients

“8.5 When clinical care extends between health sectors or across borders.

ReSPECT has been created by RCUK and is used in England, Scotland and Ireland. Wales is not using ReSPECT and currently use the All Wales DNACPR policy and documentation.

Holistic care spans health and social care sectors with teams working in partnership with patients. Clinical staff from different sectors ideally should, whenever possible, be involved at the beginning of the DNACPR process. Such input and team-working can prove helpful in deciding whether a DNACPR discussion is warranted and can assist future care across boundaries. The General Practitioner and wider primary care team can play a key role in this.

It is recognised that patients may be repatriated from cross-border providers. When a patient transfers to Wales with an active DNACPR decision, the All Wales DNACPR Form should be completed with reference to the prior discussions held and forms completed within 14 days. The form that has transferred over, or a clear copy, can be appended to the All Wales DNACPR form. During that 14 day period, the original cross-border decision remains active.

All forms in the UK, including the ReSPECT form in England and DNACPR forms in Scotland, constitute a valid clinical record of a decision process, when they have been filled in clearly and conscientiously. They inform a clinician of any important decisions and discussions that have previously occurred. Whilst DNACPR forms (including the All Wales DNACPR form, the ReSPECT form and other UK forms) are not legally binding, all such forms should constitute a part of the overall decision making process and weighing up of information to guide emergency situations, where these occur. Even where the 14 day period outlined above is breeched, it is crucial to take into consideration any form that has accompanied a patient, and give it appropriate weighting in each decision making process.

When a patient is receiving out-patient or short-term (day) care across national borders, then Local Health Boards/Trusts in Wales must notify the other providers of the current local DNACPR status of a patient. If outpatient care is delivered outside Wales then teams initiating the clinical referral also have a clinical duty to inform providers of the position in advance of the outpatient or day-care appointment.

For in-patient stays, when patients are cared for outside NHS Wales, patients should have their DNACPR arrangements immediately reviewed in the new health-setting, subject to that provider’s existing arrangements. Such patients will require support from their GP to instigate a review on discharge. For those in non-NHS settings they should be managed within the clinical governance arrangements of their long term placements which should be cognisant of, and ideally aligned to, the principles of this policy.

DNACPR forms where a person other than a GP or Consultant has signed the Senior Responsible Clinician section 6 of the All Wales DNACPR form, for instance a nurse consultant, should be given the same weighting in any new Health Board or Trust that they transfer over into, even if that healthcare setting does not have the same process of nurse consultants signing DNACPR forms. This is a national policy for all of Wales, therefore local variances in practice can be addressed by reverting back to the contemporaneous version of the DNACPR policy document.”

Taken from ' A Clinical Policy For Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales. Revised Policy v4 – November 2020

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