University Hospitals Birmingham NHS
NHS Foundation Trust

# Standard Operating Procedure: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) including Do Not Attempt Cardiopulmonary Resuscitation (Adults)

CONTROLLED DOCUMENT

## Heartlands, Good Hope & Solihull Hospitals and Community areas

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| **CATEGORY:** | Procedure |
| **CLASSIFICATION:** | Clinical |
| **PURPOSE** | To provide staff guidance with the ReSPECT process and decisions and recommendations about cardiopulmonary resuscitation (CPR) attempts at University Hospitals Birmingham, Heartlands, Good Hope and Solihull sites or community areas |
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| **Distribution:**<br>• **Essential Reading for:**<br>• **Information for:** | All Directors, Senior Managers and Department Heads, All Clinical Staff<br>All Staff |

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## 1.0 Introduction and aim

The aim of this procedural document is to set out the principles which govern the use of Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) process in adult patients. The procedure should be read in conjunction with the UHB Resuscitation policy.

This procedure has been written with reference to the latest guidance issued by the BMA / 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. The Scope of the procedure

This section of the procedure applies to all adult patients (age 18 and over). A conversation about treatment options should be held and a ReSPECT form should be completed for all those at risk of deterioration or cardiac arrest or who want to have their wishes documented.

This procedure must be made available to patients on request.

## 3. Key points for all staff

- Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) must be considered in all acute admissions. A conversation about treatment options and a ReSPECT form should be completed for all those at risk of deterioration or cardiac arrest or who want to have their wishes documented.

- Patients who have a completed ReSPECT form **MAY** still be considered for CPR attempts, subject to what is recorded in the appropriate part of the form.

- ReSPECT will remain active for the duration of the hospital admission (including subsequent discharge to community care) or community care episode unless they are clearly cancelled.

- ReSPECT should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another admitted from home or discharged home.

- The consultant/GP in charge of the patient's care carries responsibility for ReSPECT. Authority may be delegated to a registrar grade doctor or equivalent (staff grade; associate specialist; ST 3+) or a Specialist Nurse / Community Matron (band 7 or above) for patients who are on a GP practice supportive/palliative care register and who have a community nursing care plan.

- When responsibility has been delegated, the responsible consultant/GP should be informed and this should be documented in the patient's clinical record. When the consultant/GP next reviews the patient they should sign to endorse the ReSPECT form.

- Record Recommended Summary Plans for Emergency Care and Treatment on a ReSPECT form. All fields must be completed and the form then filed in the front of the patient's notes/community care plan. Additional information may be documented in the patient's notes.

- It is a legal requirement to consult with the patient (or relatives if the patient lacks capacity) when considering resuscitation recommendations. Document details of who was consulted and when on the ReSPECT form.

- Ensure the nursing staff are aware a ReSPECT form has been completed, drawing attention to any recommendations made regarding DNACPR.

**3.1 All staff must ensure they are aware of the exceptions, which are:**

- If doubt exists over resuscitation status – resuscitation should be commenced

- Clinical judgement can override ReSPECT if a readily reversible cause of a deterioration, e.g. choking, blocked tracheostomy tube, induction of anaesthesia etc., unless the patient has specifically refused intervention in these circumstances.

## 4. General Principles for all staff

- ReSPECT addresses treatment planning in relation to emergency, potentially life-extending treatment, including CPR. It should be considered for those who are at risk of a significant clinical deterioration

that may place their life at risk. Such people may already have an existing life limiting illness, such as advanced organ failure, or cancer. As a minimum, it should be considered for any person that is at foreseeable risk of cardiorespiratory arrest, as is currently the case for DNACPR forms. Additionally, a person's 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 people and clinicians, shared decision making (when possible) leading to better advanced planning, good communication and documentation and better overall care.

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

### 4.1 Reviewing a ReSPECT form

**Staff must ensure the ReSPECT form is reviewed regularly. In particular, review will be required:**

- whenever changes occur in the patient's condition;
- there is a change in the patient's expressed wishes; or,
- whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.

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

- Unless cancelled, ReSPECT covers the duration of the hospital admission/community care episode. This includes inter-site transfers between hospitals/facilities managed by UHB, including Solihull Community Services.

- ReSPECT 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 those circumstances. In an emergency, where there is no time to investigate further, the presumption should be in favour of CPR if this has a realistic chance of prolonging life.

- In the event that a patient needs to undergo general anaesthesia, a ReSPECT form should be reviewed in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. http://www.aagbi.org/

- ReSPECT decisions should be made in accordance with the requirements of the Human Rights Act 1998, the Mental Capacity Act 2005 and professional regulatory bodies e.g. General Medical Council.

- Where no explicit decision has been made in advance or there is uncertainty over a ReSPECT decision (particularly where it relates to CPR) then, in the event of a cardiac arrest, resuscitation should be commenced.

## 5. CPR recommendations and ReSPECT

Recommendations about CPR attempts must be considered as part of an overall treatment plan. Do Not Attempt CPR (DNACPR) / CPR attempts not recommended, are usually only appropriate in three settings:

- **Where attempting CPR will not restart the patient's heart and breathing**. The healthcare team must be as certain as it can that attempting CPR would not restart the patient's heart and breathing, this recommendation should be based on clinical assessment of the patient and relevant guidelines.

- **Burdens outweigh benefits -** Where the expected benefit is outweighed by the burdens e.g. terminal illness. This assessment can only be made following discussion with the patient (or relatives if the patient lacks capacity). Further details are provided in the joint BMA/RC(UK)/RCN guidance (section 7.2) http://www.resus.org.uk/pages/DNACPR.htm

- **Patient refusal -** where CPR is against the wishes of a patient with mental capacity. This 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 aged18 or over, be in writing, signed, witnessed and state that it is to apply to refusal of life- sustaining treatment even if life is at risk). Further details on advance decisions can be found in the Trust consent policy and at http://www.adrtnhs.co.uk/)

## 6. Involving patients and those close to them in decision making

- Communication is central to the safe and effective use of the ReSPECT policy.

- Discussions around emergency treatment (including resuscitation) 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, bearing in mind that consultation with a patient about their resuscitation status is required unless to do so would cause that patient harm.

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

- A patient information leaflet should be provided to the patient or their relative. These can be located on the Patient Advice and Information Database (PAID) or ordered via iproc.

### *6.1 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.

- A failure to consult with the patient may constitute a breach of that patient's rights under Article 8 European Convention of Human Rights (ECHR). A ReSPECT form should only usually be inserted in a patient's notes after consultation with the patient. Only in exceptional circumstances where the treating clinician considers *"the patient will be distressed by being consulted and that distress might cause the patient harm"* will it be reasonable not to

discuss a patient's resuscitation status with them. Reasons for not consulting the patient must be recorded.

- Harm can be psychological or physical. Distress alone would not be sufficient. A clinical view that CPR or medical treatment is futile is not a sufficient ground not to consult.

- 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 patient record. Reasons must be robust and should stand up to scrutiny. Simply recording that discussions would be likely to cause harm will not be sufficient.

- Following consultation with the patient, any ReSPECT recommendations must be recorded on the ReSPECT form. All fields must be completed and filed in the front of the patient's notes/community care plan. Additional information may be documented in the patient's notes.

- If a patient indicates they do not wish to discuss emergency treatments and resuscitation, this instruction should be respected and further attempts made to engage the patient or encourage consent to discuss ReSPECT with family members or an advocate if no family member or next of kin is available. Where a ReSPECT form is made and there has been no discussion with the patient/family, because he/she has indicated a desire to avoid such a discussion, this must be documented on the form and in the health records, with reasons given.

- Rarely, it may be considered inappropriate to discuss the recommendation with the patient, for example, where to do so would cause the patient physical or psychological harm. These cases are likely to be exceptional. If it is deemed inappropriate to discuss ReSPECT with either the patient and/or relatives, this must be documented, with reasons why. Health professionals must be prepared to justify their actions. Staff reluctance to discuss ReSPECT issues is not a sufficient reason.

- If a patient has the mental capacity to refuse emergency treatments (including CPR) you must comply with their decision and document it in the medical records including details of the discussion & advice given.

### *6.2 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 "MCA"). The starting point when undertaking any capacity assessment is a presumption of capacity.

- The MCA states that a person is unable to make a decision if, as a result of an impairment of the mind or brain, or disturbance in the functioning of the mind or brain, they are unable to:

    a. understand the information relevant to the decision; and
    b. retain that information; and
    c. use or weigh that information as part of the process of making the decision; or
    d. Communicate his/her wishes (whether by talking, using sign language or any other means).

- The outcome of the assessment of mental capacity must be recorded on the ReSPECT form.

- The Trust Consent Policy provides guidance on decision making in patients that lack capacity. The Mental Capacity Act supports care and treatment decision making in best interests by staff caring for patient that lack capacity. These policies must be followed when making ReSPECT in patients that lack capacity. The policy emphasises the importance of consulting with those close to the patient when making recommendations in best interests, weighing up the risks, benefits and burdens of resuscitation. The policy covers (i) duty to consult (ii) lasting power of attorney (iii) advance decisions and the role of IMCA's. Further details on the Mental Capacity Act and how it applies to decisions about life sustaining treatment can be found at http://www.publicguardian.gov.uk/mca/mca.htm

- In patients who lack capacity there is now a legal obligation to consult with relatives/NOK /advocate (such as an 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 well, for example, 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, please document in the case notes: (1) your attempts to contact relatives, (2) the reasons why the DNACPR recommendation has been made without their consultation and (3) your instruction that they are informed as soon practically possible.

### *6.3 If agreement cannot be reached*

- In the event of a disagreement over ReSPECT decisions between clinicians, patients and/or their relatives all attempts at resolving these differences must be made. This can often be achieved through sensitive discussions which address the fears or worries and misconceptions the patient may have, often they are worried that DNACPR means no treatment.

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

- In the event that the clinical team 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 Governance team, Trust solicitors, Clinical Ethics Committee or Resuscitation Committee should be sought.

- It is good practice to engage the patient's relatives / next of kin in discussions on CPR status, if the patient wishes for them to be involved. If a ReSPECT has been made the patient may wish their family to be informed of this but may not be able or willing to do this themselves. The relatives will need to be informed at the earliest opportunity, in a sensitive manner when they next visit the ward / department.

- Refusal by a patient with mental capacity, to allow information to be disclosed to the family and friends should be clearly documented and must be respected.

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## 7. Recording on a ReSPECT form

- A Recommended Summary Plan for Emergency Care and Treatment must be recorded on the ReSPECT form which must be filed at the front of the patient notes/community care plan. All sections of the form must be completed clearly

without medical jargon and acronyms. Remember, the form belongs to the patient so this must be understandable to them, their carers and other health care providers. Additional information may also be made in the medical notes at the time the recommendation is made. Details providing the rationale and any discussions with others should be recorded.

## 8. Cancelling a ReSPECT form

- When a ReSPECT form is cancelled it must be marked through with two parallel lines and the word cancelled written clearly along. The date, time, name and grade of person revoking the recommendations and decisions about CPR attempts, must be recorded on the form. The form must be immediately removed and filed in the correspondence section of the medical notes by the person cancelling the ReSPECT recommendation.

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

- Nursing staff have a duty to record and maintain up to date records of ReSPECT. Robust systems must be in place to ensure effective communication between shifts and whenever a patient is moved between clinical areas. The Trust electronic nurse hand-over system provides a reliable route for recording resuscitation recommendations.

## 9. Clinical responsibility for ReSPECT decisions

- The consultant/GP in charge of the patients care at the time the ReSPECT is made carries responsibility for the ReSPECT until the patient is formally transferred to the care of another consultant/GP at which point that consultant/GP will assume responsibility for the on-going ReSPECT.

- Authority may be delegated to a registered medical practitioner of a registrar grade or equivalent (staff grade; associate specialist; ST 3+). When responsibility has been delegated the responsible consultant should be informed and this should be documented in the patient's clinical record. When the consultant next reviews the patient, they should sign to endorse the ReSPECT form.

- Authority may be delegated to a Specialist Nurse /Community Matron (Band 7 or above) for patients who are on a GP practice supportive/palliative care register (patients who have been assessed as having less than 12-6 months prognosis) and who have a community nursing care plan. When responsibility has been delegated, the responsible GP should be informed and this should be documented in the patient's clinical record. When the GP next reviews the patient they should sign to endorse the ReSPECT form.

- The consultant or GP should sign the ReSPECT form at the earliest opportunity

- A ReSPECT must be made by consensus within the clinical team. This includes as a minimum nursing and medical staff.

## 10. ReSPECT in Patients Requiring Off Site Transfer

### 10.1 All staff must ensure they are aware that:

- ReSPECT remains active for the duration of hospital admission/community care episode.

- The Ambulance Service policies apply during inter hospital transfers or transfer from hospital to home / hospice etc. These policies usually dictate that the patient will be transported in a vehicle by themselves rather than with other patients which can lead to delays in the patients transfer.

- Prior to transfer the circumstances behind the ReSPECT should be reviewed and an assessment made of the likelihood of the patient deteriorating during transfer. If the reasons for the ReSPECT remain valid and the patient is considered at risk of deteriorating on route then ReSPECT should remain active during the transfer.

- In the event that ReSPECT has been made on the basis of patient refusal this should be discussed with the patient. The patient's wishes following this discussion should be recorded and must be respected.

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

- Ensure that the ReSPECT form is correctly completed and reasons for DNACPR are clearly documented in the medical notes.

- 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 form will remain in place during the transfer. Record this in the patient's medical record.

- Complete a ReSPECT discharge check list (Appendix 1) and file in the medical notes.

- Ensure that the original documentation stays with the patient.

## 11. Patients attending UHB acute services with Community DNACPR or ReSPECT forms

- Community DNACPR recommendations and ReSPECT can only be effective across healthcare settings if it is shared, without delay, with those healthcare professionals whose decisions it is intended to inform. It is essential that the person, and with his/ her agreement, their family/carers, have been involved in the process of completing the ReSPECT document, understand its content and are empowered to show it to the healthcare team in any new setting. They (or their representative if they do not have capacity) should also be involved in conversations about sharing the document across healthcare settings.

- If a patient attends hospital with a community DNACPR or ReSPECT form it should usually be reviewed with the patient (or if the patient lacks capacity a power of attorney or those close to the patient). The nature of any review of the ReSPECT document will depend on the particular clinical circumstances of the person. It may not be necessary to review the content of the document with the person or those close to them, if sufficient information has been communicated in the form of e.g. a discharge summary. This will be a matter of clinical judgement for the healthcare professional with overall clinical responsibility for a person, 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 an existing ReSPECT form). This MUST be completed before transfer from ED/AMU/SAU.

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

## 12. Patients being discharged with a ReSPECT form

### 12.1 All staff must ensure that when they discharge a patient with a ReSPECT form they:

- Review the ReSPECT recommendation and ensure all electronic discharge details relating to ReSPECT are fully completed prior to discharge.

- Complete a ReSPECT discharge checklist (Appendix 1) and file in the medical notes.

- Give the original ReSPECT form to the patient when discharged to take with them and keep at home.

- Ensure the GP and community nursing team are aware of recommendations about CPR attempts.

## 13. Patients being discharged to usual place of residence with planned frequent re-admission for treatment with a ReSPECT recommendation e.g. renal dialysis

- Patients receiving regular dialysis are exempt from a clinical review of ReSPECT on each admission for dialysis.

- Review ReSPECT and ensure all electronic details relating to the ReSPECT form are fully completed prior to discharge.

- Complete a regular re-admission sticker and apply to the original ReSPECT form.

- Photocopy the ReSPECT form and file the copy in the medical notes.

- 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

## 14. Implementation & Monitoring

This procedure and its associated policy and procedure documents are available on the Trust intranet and are disseminated to staff through the divisional management and internal team structures within the Trust. All staff must be informed of this procedure and associated documents during local departmental induction.

Monitoring of the procedure will be undertaken using the following matrix:

## 15. Associated Policies & Procedures

| MONITORING OF IMPLEMENTATION | MONITORING LEAD | REPORTED TO PERSON/GROUP | MONITORING PROCESS | MONITORING FREQUENCY |
|---|---|---|---|---|
| Recommended Summary Plans for Emergency Care and Treatment **or** Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit | Lead Resuscitation Officer | Resuscitation Committee Chair / DNACPR sub group chair & Governance Lead | Monthly audit from resuscitation service department on :<br>• Number of DNACPR decisions made in the Trust.<br>• Compliance with the agreed DNACPR documentation process and practice<br>• Implementation & Progress of action plans for non-compliance issues. | Quarterly |

This procedure document must be read in conjunction with the following Trust documents:-

- Resuscitation Policy (UHB)
- Paediatric Resuscitation Procedure (HGS)

## 16. References and Bibliography

### Professional

Resuscitation Council United Kingdom www.resus.org.uk/pages/guide.htm

Resuscitation Council, Decisions Relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, London: 2007. www.resus.org.uk/pages/DNAR.htm

Regnard C & Randall F, 2005 Clinical Medicine. A Framework for making Advanced Decisions on Resuscitation. Vol 5 (4) July/August

General Medical Council. Withholding and withdrawing life prolonging treatments: Good practice in decision-making, 2002.
www.gmc-uk.org/guidance/current/library/witholding_
lifeprolonging_guidance.asp#67

General Medical Council. Good medical practice, 2006.

www.gmc-uk.org/guidance/good_medical_practice

The Association of Anaesthetists of Great Britain and Ireland; Do Not Attempt Resuscitation (DNAR) Decisions in the Peri-operative Period; 2009 www.aagbi.org

### Legal

The Human Rights Act 1998

http://www.england-legislation.hmso.gov.uk/acts/acts1998/19980042.htm

The Mental Capacity Act 2005

http://www.legislation.gov.acts/acts2005/20050009.htm

The Department of Health Publication (HSC2000/028: Resuscitation Policy
http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms
=resuscitation+policy

**Appendix 1**

# ‘Recommended Summary Plan for Emergency Care and Treatment’ (ReSPECT) Discharge: Checklist

**Patients Name……Hospital N.O……**

**Date……. Ward…… Site BHH / GHH / SH**

**To be completed by the nurse/doctor responsible for the discharge of the patient being discharged with a ReSPECT form in place. The completed checklist must be filed in the medical notes along with the photocopy of the ReSPECT form discharged with the patient.**

| | Have you checked… | Y/N | Signature |
|---|---|---|---|
| 1 | The ReSPECT form has been reviewed and section 9 “*Confirmation of validity*” signed by the relevant doctor (ST3 or above) and documented that these recommendations will remain in place on discharge ? | | |
| **If you are unsure at this point please contact a doctor responsible for the patients care as a matter of urgency to discuss further.** | | | |
| 2 | Is the patient/their relatives/representatives aware of the ReSPECT form including the recommendations about CPR?<br>Ensure the ReSPECT form includes documentation in section 6 *“Involvement in making this plan*” | | |
| 3 | If the patient lacks capacity has an appropriate representative been involved in the decision and this indicated on the ReSPECT form? | | |
| 4 | Is there documentation in the patients’ medical notes that the patient, or if patient lacks capacity, relevant other, have been informed that a ReSPECT form is in place on discharge and are aware of recommendations about CPR? | | |
| 5 | Are all patient details entered correctly on the ReSPECT form? | | |
| 6 | Has the ReSPECT form been signed by or endorsed by a Consultant?<br>(Section 7 and or 9) | | |
| 7 | Have teams involved in the patients community care been informed (including ambulance services) and the e-TTO updated that a ReSPECT form is in place on discharge and are aware of recommendations about CPR?<br>List teams informed below | | |
| 8 | Has a **photocopy** of the current ReSPECT form been appropriately marked through with “not for clinical use” with a signature and date and filed in the correspondence section of the medical notes”? | | |
| 9 | Has the patient got the original ReSPECT form to take with them? | | |

**If the answer is No in any section 1 – 9 then a doctor responsible for the patients care must be contacted for guidance.**

If the ReSPECT form is not to remain in place on discharge then the decision should be cancelled as per ReSPECT policy.

For further information please refer to the current ‘Recommended Summary Plan for Emergency Care and Treatment’ (ReSPECT) procedure or the HGS Resuscitation Service intranet site.