Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) policy

This is a new procedural document and incorporates: PAT/EC 2 v.9 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

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Amendment Form

Please record brief details of the changes made alongside the next version number.
If the procedural document has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Authors
Version 1	1 April 2019	This is a new procedural document, **PLEASE READ IN FULL.**	Nicola Vickers Jonathan Allen Nagendra Rao

Contents

1 INTRODUCTION

This policy is for all patients including children and young people and is intended for use alongside the national Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form. This policy addresses issues relating to the planning of emergency care and treatment and includes CPR decisions.

All staff employed by Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust are expected to comply with this policy.

ReSPECT is an approach to discussing, making and recording recommendations about future emergency care and treatment, including, but not limited to, cardiopulmonary resuscitation (CPR). ReSPECT focuses on treatments to be considered as well as those that are not wanted or would not work.

It is important to be aware that a patient can have a ReSPECT and not a DNACPR.

Where no explicit decisions about treatment and CPR have been considered and recorded in advance there should be an initial presumption in favour of full escalation and CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start CPR will be appropriate.

Furthermore some people may wish to make an Advance Decision or statement about treatment stating they would not wish to receive such treatments in some future circumstances. These people should be managed in accordance with their wishes.

Making decisions not to use certain treatments and/or attempt CPR that have no realistic prospects of success do not require the consent of the patient or those close to the patient however, **any decisions about treatment and/or CPR should always be communicated to the patient, if they have sufficient mental capacity, or relevant others (subject to any confidentiality restrictions).** Informing the patient and relevant others of these decisions with a clear explanation will make conflicts of opinion highly unusual situations however should these decisions not be accepted by the patient or their relevant others then a second opinion should be offered.

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) Decisions relating to cardiopulmonary resuscitation. It is also written with due regard for the requirements of the Mental Capacity Act (2005).

This policy should also be read in conjunction with the relevant professional standards and guidelines including the Nursing and Midwifery Council (NMC) publication The Code - Professional standards of practice and behaviour for nurses and midwives (2015) and the General Medical Council (GMC) publication: Treatment and care towards the end of life; good practice in decision making (July 2010)

2 PURPOSE

The purpose of this policy is to ensure that Trust staff are aware of their responsibilities in relation to ReSPECT recommendations and processes and are fully supported in their role so patients receive appropriate care. In particular the policy aims to achieve a coordinated approach across the Doncaster & Bassetlaw locality so the transfer of patients between services does not compromise dignity, quality of care or patient choice.

Specific objectives include:

- to ensure decisions regarding emergency care and treatment are made according to;
  - the clinical needs of the patient and assessment of whether treatments will be successful
  - the patient's wishes and best interests
  - current ethical principles
  - legislation such as the Human Rights Act (1998) and Mental Capacity Act (2005)
  - relevant court judgments
- to make emergency care and treatment recommendations transparent and open to examination and ensure patients, relevant others and staff have clear information about the process and their involvement
- to avoid inappropriate CPR attempts
- to ensure patients, relevant others and staff have clear information about the ReSPECT process and their involvement
- to encourage and facilitate open, appropriate and realistic discussions with patients and their relevant others about emergency care and treatment issues including CPR and to give guidance on good practice when having these discussions
- to ensure any decisions are communicated to all relevant healthcare professionals and services involved in the patient's care

ReSPECT is appropriate for:

- Anyone – but with increasing relevance for those:
  - with particular healthcare needs
  - nearing the end of their life or at risk of cardiac arrest
  - who want to record their preferences for any reason
- ReSPECT can be used for people of any age but when used for a child or young person there must be appropriate parental involvement
- The ReSPECT form can generally be used to support discussions with patients and relevant others.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005) and

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is determined on an individual basis and the starting point is the strong presumption that it is in a person's best interests to stay alive. From a legal standpoint a recent Supreme Court judgment interpreted this statute for us and presented it in lay persons terms and stated that

'*in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be.' (Lady Hale)*

This policy must be read alongside the following associated procedural documents:

- PAT/PA 19 - Mental Capacity Act 2005 Policy and Guidance
- PAT/EC 1 - Resuscitation Policy
- PAT/PA 27 - Advance Decisions to Refuse Treatment (ADRT) Policy
- PAT/PA 2 - Policy for Consent to Examination or Treatment

3 DUTIES AND RESPONSIBILITIES

It is the responsibility of the ReSPECT implementation and Patient Safety Review Groups to ensure implementation. The Policy Co-ordinator is responsible for policy distribution. Compliance against policy will be monitored and reported by the Resuscitation and Manual Handling Lead.

It is the responsibility of Divisional Directors, Associate Directors of Nursing, Heads of Therapies, Midwifery and Paediatric Nursing, General Managers and Matrons to ensure that ALL clinical staff are aware of this policy.

It is the responsibility of all clinical staff to familiarise themselves with this policy and apply its principles in clinical practice.

In DBTH responsibility for making ReSPECT decisions sits with the patient's Consultant after consultation with the patient and/or relevant others and the Multi-Disciplinary team where possible. In their absence, the most senior Healthcare Professional (Foundation Year 2 medic or above or qualified Advanced Clinical Practitioner) is responsible for the immediate decisions and for notifying the patient's Consultant as soon as is practical to do so.

It is the responsibility of the patients Consultant to ensure all decisions are communicated to the patient and/or relevant others if they have not been involved in

the decision making process. Whilst the Consultant caring for the patient carries the ultimate responsibility, there may be situations where another member of the healthcare team is best placed to discuss and explain the decisions to the patient and/or relevant others so this may be delegated.

4 PROCEDURE

4.1 General Principles

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

ReSPECT addresses treatment planning in relation to emergency, potentially life-extending treatment and DNACPR. It should be considered for those patients who are at risk of a clinical deterioration that may place their life at risk. These patients may already have an existing life limiting illness, such as advanced organ failure, or cancer. The scope of ReSPECT can cover other treatments, for example, antimicrobial therapy in those at risk of infection, ventilation in those at risk of respiratory failure or artificial nutrition/hydration in those at risk of aspiration. Additionally, patient wishes may lead to a ReSPECT document being considered, discussed and used, even in the absence of advanced, or indeed any, illness.

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

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

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

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

4.2 Resuscitation Decisions and ReSPECT

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

DNACPR decisions are usually only appropriate in three settings;

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

It is important to note a patient can have a ReSPECT in place and be <u>for resuscitation</u>.

4.3 Discussion with Patient/Relevant Others

The Resuscitation Council (UK) / RCN / BMA Guidance Decisions relating to cardiopulmonary resuscitation (2016) provide general guidance on deciding when and how approaches to patients and relatives should be made. The circumstances of each patient should be considered and a plan formulated on a case by case basis. Discussions around emergency treatments should be undertaken sensitively. Clinicians should be responsive to verbal and non-verbal communication signals from the patient which may indicate the extent to which they wish to be involved in these discussions.

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

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

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

Harm can be psychological or physical. Distress alone would not be sufficient grounds not to discuss ReSPECT with the patient/family. A clinical view that CPR or medical treatment is futile is not a sufficient reason not to inform the patient/family.
In the rare circumstances where a clinician has sufficient grounds to believe discussion with a patient about their resuscitation status would cause that patient harm, that clinician must clearly record the reasons for this in the medical notes. Reasons must be robust and health professionals must be able to justify these.

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

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

Where there is a question about a patient's capacity to be involved in discussions about emergency treatments, an assessment of that patient's mental capacity must be carried out in accordance with the test set out in the Mental Capacity Act 2005. The starting point when undertaking any capacity assessment is a presumption of capacity. The outcome of a mental capacity assessment must be recorded on the ReSPECT form and the Trust Mental Capacity Assessment documentation completed.

In patients who lack capacity there is a legal obligation to consult with relatives, friends or an advocate (such as an Independent Mental Capacity Advocate IMCA), when considering a DNACPR recommendation. This might mean delaying a DNACPR recommendation until reasonable and practical steps have been taken to consult the relatives. Such steps may include telephoning at night, which whilst that might be less convenient or desirable than a meeting in office hours, does not mean it is not practicable. In the case of a rapidly evolving clinical scenario when decision making needs to proceed before relatives can be contacted, the following should be documented in the case notes: (1) what attempts have been made to contact relatives, (2) the reasons why the DNACPR/treatment plan recommendation has been made without their consultation and (3) clear instruction that they are informed as soon practically possible.

4.4 Children and Young People – Special Considerations

In Doncaster & Bassetlaw, the large majority of children needing Palliative care are under the care of specialists in Sheffield or Leeds however there may be situations when clinicians at DBTH need to initiate/complete the ReSPECT process.

Who should or could initiate the discussion, and when?
It can be appropriate for professionals caring for children and young people with life limiting or life threatening conditions to initiate a discussion about end of life planning well before the child or young person is terminally ill. It may also be appropriate to

begin discussions if a child or young person has an acute illness or repeated illness as a result of which it becomes clearer to professionals and/or the parents that child or young person is moving into a terminal phase of their illness, or that they are at an increased risk of a more sudden life threatening illness/event. Usually the most appropriate professional to initiate this discussion is the named paediatrician or palliative care practitioner.

If professionals initiate a discussion, consideration should be given to the sensitive timing of this and further support for the family and young person may be necessary. Decision making should not be forced on a young person or family. If a professional initiates a discussion about ReSPECT and the young person/family indicate they do not wish to continue, their wishes should be respected and the details recorded in the medical notes.

Discussion may also be initiated by the young person or family at any time.

Who can make decisions?

For children

Parental ability to make decisions concerning a ReSPECT for their child is governed by the Mental Capacity Act, 2005. For further information on what is, and who has, parental responsibility, refer to PAT/PA 2 - Policy for Consent to Examination or Treatment.

Every effort should be made to communicate with the family in such a way that they can understand the information given and respond with their decision.

For young people

The Department of Health (2009) state that:

By virtue of section 8 of the Family Law Reform Act 1969, young people aged 16 and 17 are presumed to be capable of consenting to their own medical treatment. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

In exceptional circumstances it may not be possible for all concerned to reach a united decision regarding the best interest of the young person. If this cannot be resolved by the patient's Consultant, the Consultant should request further advice from regional experts, Trust Medical Director and Trust Legal Services Department.

To establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention; the same criteria should be used as for adults. If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over (Department of Health 2009).

Where a young person lacks capacity to decide, a person with parental responsibility for the young person may make a ReSPECT decision where they consider that to be in the young person's best interests.

If a 16 or 17 year old is capable of making an informed decision then it is not legally necessary to obtain additional consent from a person with parental responsibility. It is, however, good practice to involve the young person's family in the decision-making process – unless the young person specifically wishes to exclude them.

If a young person decides that he/she does not wish to be resuscitated and that the family should not be involved with or informed about the decision this must be urgently referred to the Trust Medical Director and Legal Services Department.

Children in local authority care

Where a child is in the care of the local authority the child's social worker must be involved in all of the discussions as well as parents, as the local authority shares parental responsibility with the parents. However, when a child is in voluntary care (Section 20, Children Act 1989) the parents retain full parental responsibility.

What happens when a young person and a person with parental responsibility disagree about a ReSPECT decision?

Decision-making with young people may be a matter of negotiation between the child, those with parental responsibility and clinicians. Inevitably there will be times when young people and those with parental responsibility for them do not agree about whether treatment and/or DNACPR decisions should be made. If there is disagreement between the patient and those with parental responsibility despite attempts to reach agreement, legal advice should be sought.

What happens when medical staff and a young person or persons with parental responsibility disagree about a ReSPECT decision?

Where medical staff are strongly of the opinion that further treatment or cardiopulmonary resuscitation should not be attempted but the parents, young person or people with parental responsibility disagree, or vice versa, a legal opinion should be sought.

Safeguarding issues

Where there is doubt about whether a person with parental responsibility is acting in the interest of the child/young person, then local Safeguarding Children Board procedures must be instigated. For further advice please contact the Trust Safeguarding Team.

Education Establishments

Potentially a child or young person may wish to continue at school with an agreed ReSPECT decision in place. This can potentially cause anxieties for both the family and staff supporting that child or young person. Advice can be sought from a palliative care practitioner in dealing with those anxieties and what measures can be put in place to support the child and family during this period.

4.5 Reviewing a ReSPECT

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

When a ReSPECT is cancelled the form should be marked through with two parallel lines and the word "cancelled" written clearly between the lines. The date, time, name and grade of person revoking the ReSPECT should be recorded on the form. The form should be immediately removed and filed in the correspondence section of the medical notes. Amended ReSPECT forms must not be destroyed as they are an important record of discussions and decisions. An entry fully recording the reasons for this change in recommendation must be made in the patient's medical notes.

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

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

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

4.6 Record Keeping and Internal/Interagency Communication

Good record keeping and effective communication are central to the safe and effective use of ReSPECT.

ReSPECT recommendations should be recorded on the nationally recognised form which should be filed at the front of the patient's medical notes behind the yellow hazard warning card or in the front of the episode of care folder (where applicable) while the patient is in hospital. All sections of the form should be completed and the circumstances surrounding the decision must be clearly stated together with who was involved in the decision making process. The decision and decision making process should be evidenced with full and clear documentation in the patient's medical notes.

Nursing staff have a duty to record and maintain up to date nursing records of ReSPECT including resuscitation. Robust systems must be in place to ensure effective communication between shifts and whenever a patient is transferred between clinical areas (e.g. ward to Radiology).

Communication of these decisions both internally and externally is essential.

See Appendix 1 for agreed Trust procedures.

The following principles apply**:**

- The person who makes a ReSPECT decision is ultimately responsible for ensuring that the decision is communicated effectively to other relevant health professionals in both primary and secondary care. The task of disseminating information about the decision to others providing care to the patient may be delegated to another member of the healthcare team, but it should be clear who has responsibility for ensuring that this task is undertaken.
- The senior nurse is responsible for ensuring that every ReSPECT decision is recorded in the nursing records (where medical and nursing records are held separately) and that all those nursing the patient are aware of the decision.
- Whenever a patient is transferred between establishments or discharged home it is imperative that ReSPECT decisions are communicated between all who need to know, including the ambulance crew, GP, community nursing team, hospice, care home and any relevant others and this should be managed in a sensitive manner.

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

5 TRAINING/SUPPORT

The training requirements of staff will be identified through a learning needs analysis. Role specific education will be delivered by the service lead.

Training on this policy will be incorporated into all resuscitation training sessions delivered within the Trust. All training will be recorded centrally on OLM.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Overall compliance with the policy.	Resuscitation Lead in conjunction with all clinical areas & the clinical audit department.	Monthly audit with six monthly reporting.	Findings will be reported to the Patient Safety Review Group six monthly.

Any other audit which is undertaken within the Trust will be shared collaboratively with Resuscitation Services.

7 DEFINITIONS

Healthcare Professional
A Registered Nurse, Doctor or Allied Healthcare Professional.

Cardiopulmonary Resuscitation (CPR)
An emergency procedure that may involve the following actions in an attempt to restart the patient's heart and breathing:

- Chest compressions (external cardiac massage)
- Ventilation of the lungs
- Defibrillation

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
A clinical decision not to commence cardiopulmonary resuscitation.

Mental Capacity
The ability of an individual to make decisions regarding specific elements of his life.

Mental Incapacity
A person lacks sufficient capacity in relation to a matter if, at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain. This lack of capacity may be permanent or temporary.

Advanced Decisions to Refuse Treatment (ADRT)
An advance decision made by any person aged 18 years or over, whilst having mental capacity, to refuse specified medical treatment or intervention for a time in the future when they may lack the capacity to consent to or refuse that treatment.

Independent Mental Capacity Advocate (IMCA)
An independent advocate appointed to support vulnerable patients who lack mental capacity and have no one appropriate to act on their behalf. IMCAs can also become involved if staffs conclude that relatives/other carers may not be acting in a patient's best interests.

Lasting Power of Attorney (LPA)
A legal document whereby an individual (the donor) authorises another person (the done) to act on his behalf, in the event that the donor should lose the capacity to make his own decisions. This authority can be in respect of decisions regarding personal welfare and consent to medical treatment. In order to be valid an LPA should be executed on the prescribed form and registered with the Public Guardian. If it applies to end of life decisions this must be clearly stated.

Young Person
Within the context of this policy, the term young person refers to any patient aged 16 or 17 years of age.

Patient's responsible Consultant
The Consultant currently in charge of the patient's care.

Relevant other
For the purpose of this policy, relevant other may include: spouses, partners, relatives, carers (who are not acting in a paid, professional capacity), representatives, advocates, people with lasting power of attorney, IMCAs and court appointed deputies.

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 2)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Resuscitation Policy - PAT/EC 1

Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty

Safeguards (DoLS) - PAT/PA 19

Advance Decisions to Refuse Treatment (ADRT) Policy - PAT/PA 27

Safeguarding Adults Policy - PAT/PS 8

Safeguarding Children Policy - PAT/PS 10

Rapid Response to Unexpected Child Deaths and Child Deaths Function Standard

Operating Procedure – PAT/T 62

Consent to Examination or Treatment - PAT/PA 2

Doncaster Safeguarding Adults Procedures

Nottinghamshire Safeguarding Adults Procedures

Doncaster Safeguarding Children Procedures

Nottinghamshire Safeguarding Children Procedures

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu-general-data-protection-regulation-gdpr/

11 REFERENCES

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APPENDIX 1 – STORAGE OF THE ReSPECT FORM AND INTERNAL/INTERAGENCY COMMUNICATION

Introduction

The flow of information and correct documentation is crucial to the success of this process. Where an individual may move care settings, including on discharge to the patients home, and the **ReSPECT** decision has been reviewed **and still applies**, the following core principles apply:

Whilst in Hospital

- Whilst in Hospital, any current ReSPECT form (both copies) must be filed at the front of the Episode of Care folder.
- In areas where Episode of Care folders have not yet been implemented, the ReSPECT forms will remain in the case notes, which should be documented on and filed behind the yellow hazard warning sheet at the front of the medical records. If the patient dies whilst in hospital, both copies should be filed within the main body of the medical records.
- If the ReSPECT is valid on discharge, the original copy should be sent with the patient and the 'copy' filed at the front of the case notes.

Management of ReSPECT forms initiated outside the Trust

- When a patient is admitted to hospital with an existing valid form, this should be copied and the word 'copy' should be written on it. The copy should be filed with the original in the case notes. If the patient is discharged the original should be returned to the patient prior to leaving the hospital. If the decision is cancelled the same process should be applied as for all ReSPECT forms.

On Discharge/ Transfer

- On discharge, the top copy of the form will follow the patient to their destination (this could be patients own home, nursing home or other care facility). When the top copy (original copy with ink signature) of the form is following the patient to another setting, the second copy of the form (watermarked COPY) is to remain in the medical records. As the patient moves between care settings (including the patients home), the ReSPECT form moves with the patient in a clearly marked envelope and remains in their possession.
- When a patient travels by ambulance, the discharging ward/department will give the original ReSPECT form to the ambulance crew in a clearly marked envelope who will formally hand-over the ReSPECT form to the member of staff receiving the patient, or to the patient/relevant others on arrival at their destination.
- When a patient travels by other means i.e. with relevant others, it is essential that the ReSPECT form is given to the patient or relevant others (as appropriate) and that they

understand its importance. **This is the final part of the ReSPECT process and should not be the first time the patient and if appropriate relevant others are made aware of its existence**.

- In all other care settings (which may include the patient's home) the ReSPECT form should be located in the front of the care / nursing record. If no nursing record exists, the patient/family/carer will determine the best place to store it, and communicate this to appropriate health care professionals i.e. warden/carer/district nurse for future access if required.
- It is essential that as part of discharge planning, the doctor responsible for the patients care informs the patient's GP. **Information about ReSPECT must be included in the discharge letter in the future management GP section on the JAC system** and out of hours service as appropriate. This role may be delegated but is paramount to the communication process.
- All other care providers must also be informed about the ReSPECT PRIOR to discharge i.e. carers/ wardens/ district nurse etc., this role may be undertaken by the ward nursing staff as part of discharge planning.

Liaison with Ambulance Services

- Ambulance control must be informed that a ReSPECT form exists at the time of booking a patient transport services (PTS) ambulance.
- Ambulance crew (the registration clerk) will routinely request the DNACPR status at the point of booking patient transport services, and communicate this to the crew.
- If an ambulance is called in an emergency that is not life threatening but requires transfer to ED, i.e. from a community hospital or home, the crew will be handed the care record with the ReSPECT form at the front of it, **or** a clearly marked envelope with the ReSPECT form in. On arrival at ED the crew will formally hand-over the ReSPECT form to the member of staff responsible for the patient.

Cancelling a ReSPECT Form

To cancel a ReSPECT form, both copies must be marked with two diagonal lines and the word CANCELLED should be written across the form between the lines with the date and the signature of the clinician cancelling the form. The rationale for cancelling the form should be documented within the medical records and should state who this has been discussed with. Both copies (where available) should be filed within the main body of the medical records.

APPENDIX 2 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
ReSPECT Policy - PAT/EC 8 v.1	Resuscitation Services	Nicola Vickers	New policy	February 2019

1) Who is responsible for this policy Department of Quality & Governance and Resuscitation Services

2) Describe the purpose of the service / function / policy / project/ strategy? Advance care planning for emergency situations

3) Are there any associated objectives? This policy reflects national guidelines in decisions relating to cardiopulmonary resuscitation

4) What factors contribute or detract from achieving intended outcomes?

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** N/A

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: February 2022

Checked by: Jonathan Allen **Date: February 2019**