ReSPECT

Recommended Summary Plan for Emergency Care and Treatment

Place policy for use across all organisations in Doncaster

This procedural document supersedes: PAT/EC 8 v1 - Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) policy

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1. Introduction

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

This policy details the standards, considerations, and procedures within Doncaster, relating to the initiation and journey of the ReSPECT form and process including a broad range of treatment and care decisions, particularly those relating to life sustaining treatment, including but not exclusively, cardiopulmonary resuscitation.

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

This policy therefore places emphasis on the need for quality discussions by clinicians with patients, as early as possible in the patients' journey. For example, this may be at the diagnosis of a long- term condition or when identified as entering last year of life, but this policy will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

Adherence to this process supports the provision of a holistic approach which involves individual assessment, assists patients to make informed decisions and voice their preferences, to maintain the patient's dignity, and respect of their free will.

2. What is ReSPECT?

The ReSPECT form is **more** than a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form.

ReSPECT is a **process**, and its aims are to promote constructive conversations between people and their clinicians encouraging high-quality, individualised, shared decision-making with people, including in particular those who are at risk of acute deterioration, and to promote high-quality documentation of such discussions and decisions.

Advance care planning can happen at any stage and the person's wishes, or statements may lead to a ReSPECT document being considered, discussed, and completed even in the absence of advanced illness.

This policy aims to promote emergency planning conversations between patients and clinicians as early as possible, initiated particularly for those-

- at the onset of frailty/ageing
- at the point of a long-term condition diagnosis

- a change/deterioration in condition

resulting in better advanced care planning, good communication and better overall care.

Those with complex care needs and/or co-morbidities may require a detailed advanced care plan to supplement the ReSPECT documentation and to support in key decision making in an emergency situation. Further advice on advanced care planning is provided in section 9.

2.1 What is a ReSPECT Conversation?

ReSPECT conversations follow the ReSPECT process by discussing the following-

1. Treatment.

The ReSPECT process is not solely aimed at decisions about limiting treatment; it is intended to support people to articulate and share their views about treatments and approaches to care that they **do** want, as well as about those that they don't.

The process and document can cover recommendations about both specific treatments (such as clinically assisted nutrition) and approaches to care (such as whether a person would want to be taken to hospital in an emergency) with the clinician explaining sensitively advance decisions about treatments that clearly would not work in their situation.

2. Emergency Response

This is about 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 and using that to record an agreed focus of care (either more towards life-sustaining treatments or more towards prioritising comfort over efforts to sustain life).

3. Cardiopulmonary Resuscitation

Making and recording a shared decision about whether or not CPR is recommended. Decisions about whether or not to initiate CPR are **one** element of emergency treatment plans. Increasing evidence suggests that considering whether or not to attempt CPR and discussing CPR in the context of overall goals and other types of care and treatment that might be needed, reduces incidences of harm compared to focusing only on 'Do not attempt cardiopulmonary resuscitation.

The ReSPECT **document** is intended to extend to a wider set of clinical decisions that can detail a planned system of proactive treatment and care and/or form part of an emergency response, **in addition** to decisions regarding CPR.
Guidance on actual completion of the form can be found here:
ReSPECT Resources | Resuscitation Council UK

Where practicably possible, 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 themselves has lost capacity to participate in making those decisions.

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 agreed clinical recommendations on a ReSPECT form.

A person can still have a ReSPECT form in place and require CPR.

ReSPECT is not a legally binding document. It does not override clinical judgment in the event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged when the recommendation was made, provided that there is not a valid and applicable advance decision expressly refusing such intervention.

In an emergency, the presumption should be in favour of CPR if this has a realistic chance of prolonging life. Examples for overriding ReSPECT in favour of treatment include choking and a blocked tracheostomy.

2.2 Completion of a ReSPECT document and record-keeping

A fundamental principle of the ReSPECT process is that the 'active' document should accompany the person in whatever healthcare setting they may be. Usually, this will require the person having the document in paper format when they are at home. A crucial aspect of ReSPECT is that it should be available to and easily accessible by the relevant healthcare professionals who may have to provide care and make immediate decisions in an emergency situation.

As the ReSPECT document is a summary of detailed conversations and planning that may have taken place on more than one occasion, it is essential that a comprehensive record of such is documented in the person's medical record. An entry in that record should also state the date and time of completion of the ReSPECT document.

If there is a subsequent significant change in the plan of care for a person, a new ReSPECT document should be completed and the old one clearly marked as cancelled and added to the person's medical record. An entry should also be made in the person's current health record stating the date and time that the document has been amended or cancelled and recording details of any new document completed. The healthcare professional with overall clinical responsibility is responsible for ensuring that this has been done.

The healthcare professional that has completed a ReSPECT document for a given person, including amending, or cancelling the document, is responsible for ensuring adequate and timely handover to other members of the healthcare team. This includes sharing electronically, where possible. All sharing of a person's ReSPECT information should be documented clearly.

2.3 Amending or cancelling a person's ReSPECT document

Following the patient's journey, the form should be reviewed and if necessary updated if and when –

- The patient's circumstances change (including their personal wishes and overall health)
- They have a change in care setting* (on admission **and** discharge from a hospital setting, admitted into a care home etc.) See below for further information.
- The responsible clinician feels it is appropriate to do so (good practice suggests every six months)

***Prior to discharge the content of the ReSPECT document, including the recommendation about CPR, should be reviewed, and recorded as such.

The ReSPECT document that accompanies the person on discharge should be the most recent, 'active' version. The latest version document must be photocopied at discharge and be retained in the front section of the notes, the original copy accompanies the patient.

It will also be helpful to the health and care teams in the new setting (i.e., GP, care home) if this information includes the relevant timescale for review of the ReSPECT document.

The ReSPECT process and summary details **must** be conveyed to the patient's own GP in writing as part of the discharge summary or the discharge letter (electronically where possible). It is recommended that the GP reviews the contents of the ReSPECT form with the individual within a reasonable timeframe to ensure it remains reflective of their wishes as they recover post discharge.

A ReSPECT document should be cancelled when its contents are no longer valid, or no longer applicable. For example, this may be because the person's clinical condition has changed; because they have requested cancellation; or because of a change in the assessment of the best interests of a person who lacks capacity.

2.4 Validity and Applicability of a ReSPECT document

A person's ReSPECT document will remain valid as an up-to-date plan for emergency care and potentially life-sustaining treatment until it is cancelled, or unless the decision-maker at the time has reasonable doubt that the document is not valid, or not applicable to the current situation. The decision-maker should bear in mind that they should have good reason for and be prepared to justify a decision to go against an existing ReSPECT document that is valid and applicable.

Where a patient has lost capacity for the relevant decisions, the ReSPECT document should be used as a guide to best-interests decision-making by healthcare professionals in an emergency including potentially life-sustaining treatments.

A ReSPECT document (with or without DNACPR decision) will be considered valid if it is either the original purple document or printed and completed with a wet signature, or if it is a copy (print out) of the original document but it has been dated and countersigned to state that it remains up to date.

2.5 ReSPECT for people who lack mental capacity to discuss recommendations and plans for their care and treatment in a future emergency situation

The ReSPECT document may be used to document recommendations for people who lack the mental capacity to discuss and make informed, shared decisions about their care. The Mental Capacity Act 2005 (MCA) sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves and applies to people ages 16 years and over. More information on the MCA can be found here: Mental Capacity Act 2005 (legislation.gov.uk)

Clinicians involved in the ReSPECT process should be familiar with:

- when and how to assess a person's mental capacity
- when and how to make decisions that are in the best interests of a person who lacks capacity
- when and how to involve advocates and proxy decision-makers in relevant decisions.

If a person over the age of 16 lacks mental capacity to make a particular decision under the MCA, any decisions regarding their treatment must be made in their best interests, unless the decision is covered by a legally valid and applicable ADRT refusing the treatment in question.

There must be involvement of:

- anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- anyone engaged in caring for the person or interested in their welfare,
- any recipient of a lasting power of attorney for health granted by the person, and
- any deputy appointed for the person by the court unless it is not practicable or appropriate to consult them.

The person's mental capacity, lack of mental capacity, and/or the existence of a proxy decision-maker (e.g. a recipient of Lasting Power of Attorney with relevant legal powers), and/or the existence of a valid and applicable ADRT *should* be recorded in the ReSPECT document as well as in the person's current health record. Those with complex care needs may require an advanced care plan to supplement the ReSPECT documentation.

2.6 Roles and responsibilities for completion of the ReSPECT process

When embarking upon this process, **all** health and social care staff must:

- Have accessed relevant training and education to authorise them to perform this role
- Have considered and accessed the policy to clarify any concerns where relevant and/ or consulted a more senior or experienced clinician/staff member.
- Respect the wishes of the patient wherever possible
- Meet the requirements of this policy, the standards, and behaviours of an employee of their organisation and of their profession

In addition, senior clinicians (signatories) are also to:

- Comply with any legally binding advance refusal of treatment including cardiopulmonary resuscitation or other life sustaining treatment, as part of an existing, valid, and applicable Advance Decision to Refuse Treatment (ADRT)
- Ensure the statutory process of a best interest assessment is completed where the patient lacks capacity to be involved in the decision- making process and there is no pre-existing legally binding ADRT or specific Lasting Power of Attorney's with these powers
- Provide benefits that are not outweighed by burden
- Maintain overall responsibility for the details on the ReSPECT form, providing signatures, and countersignatures where applicable.

2.6.1 GPs/Consultants

In the community, the overall clinical responsibility for decisions in relation to ReSPECT, CPR, and details on the form, lies with the GP in charge of the patient's care.

When a patient is **admitted** to hospital, the responsibility as above lies with the Consultant in charge of the patient's care, until they're discharged.

The GP/consultant may wish to delegate this responsibility to a suitably qualified clinician, see point 2.6.3.

Attendance at the Accident & Emergency Department

In a situation where a patient experiences an acute episode resulting in an A&E attendance, the Consultant overseeing their care is responsible for ensuring that a timely request to review, and where appropriate update, the ReSPECT document is communicated to the GP. Clinical recommendations are encouraged as part of this communication.

2.6.2 Junior Doctors

In some situations where a discussion surrounding ReSPECT takes place with a junior doctor with a patient, relative, carer or Independent Mental Capacity Advocate (IMCA), the doctor must refer to a more senior colleague, the consultant/GP responsible for the patient's care. Any such decision made by a junior doctor must be reviewed and countersigned by the Consultant responsible for that patient at the first available opportunity prior to discharge.

2.6.3 Advanced Clinicians

An advanced clinician is a suitably qualified clinician with the skills and ability to assess, diagnose and treat.

A GP/Consultant may delegate the responsibility of the ReSPECT process to a suitably qualified advanced clinician. The clinician is then responsible for having a ReSPECT conversation with the patient (and/or family/carer where appropriate), completing and signing the form.

The advanced clinician **must** have received an appropriate level of training and be comfortable, competent, and confident in undertaking the process.

The roles and responsibilities of **all** staff include proactively promoting and discussing advance care planning and initiating the ReSPECT process wherever appropriate. The process itself **must** be carried out by a senior clinician with the correct level of training.

3. Children and Young People

In Doncaster, 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 within Doncaster need to initiate/complete the ReSPECT process.

3.1 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 the 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 children's 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.

3.2 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 (legislation.gov.uk)
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, Medical Directors and Legal Services.

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.

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.

3.3 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.

3.4 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.

3.5 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.

4. Training and further support

In order to achieve a standardised level of training across Doncaster for all health and social care partners, there is an expectation within this policy for staff to be competent and trained in relation to ReSPECT in accordance with the expectation of their role.

The tiered training is as follows:

Tier one

As a minimum, this is aimed at **all** health and social care staff and forms part of the mandatory training to ensure staff have a general awareness of the ReSPECT process. Resources can be utilised from the Resuscitation Council website including a leaflet and the option to watch 'Joe's story video' (6 mins).

Tier two

This is aimed at staff who are directly caring for patients i.e., community nurses, practice nurses, general hospital ward nurses, and any healthcare professional in regular contact with patients who may benefit from a ReSPECT form. Tier two staff are expected to have completed the 'What is ReSPECT' module provided by the national ReSPECT e-learning tool, with evidence recorded. Further research is recommended but is individuals' choice.

Tier three

Tier three training is aimed at staff who will be carrying out the ReSPECT conversation and completing the form i.e., Doctors, Consultants, Advanced Clinicians (an advanced clinician is a suitably qualified clinician with the skills and ability to assess, diagnose and treat). It is the responsibility of each organisation to identify who is deemed appropriate to carry out the ReSPECT process.

The expectation is that these staff members complete **all** modules (40 mins) on the national ReSPECT webpage with evidence recorded.

In addition, there must be a degree of flexibility across the system to share expertise, education and provide support in delivering additional tier three training in the form of workshop, table -top discussion and scenario/case base learning. Organisations are encouraged to work together across the system to ensure there is no inequity in ReSPECT education and training.

The national e-learning modules can be found here: ReSPECT (respectprocess.org.uk)

Further information and useful resources on ReSPECT can be found here:
ReSPECT for healthcare professionals | Resuscitation Council UK

5. General Principles

Variations in local policies can cause misunderstandings and lead to distressing incidents for patients, families, and staff. Increased movement of patients and staff between different care settings makes a single, integrated, and consistent approach to this complex and sensitive area a necessity. Therefore, agreement has been reached across providers to implement a single policy which applies to **all** multidisciplinary health and social care teams involved in patient care across Doncaster.

By working together as a system, organisations collectively acknowledge and agree to adhere to, the principles of ReSPECT which revolve around a desire to ensure patients get the care and outcomes they value by:

- Encouraging patients to think about and communicate what outcomes they value and which ones they fear the most
- Facilitating clinicians to make and record recommendations for care and treatment based on these patient preferences
- Ensuring that these clinical recommendations are summarised in a plan for emergency care and treatment
- Ensuring that the recommendations are recognised and respected by pre-hospital, primary and secondary care

6. Commitment from Organisations

Organisations who agree to adhere to this policy also commit to the following:

- Ensuring all staff access the most appropriate level of education and training to enable us to embed the ReSPECT process/conversation within the system

- To raise awareness of the ethos of ReSPECT and the importance of early conversations, documenting, and sharing those outcomes and updating appropriately

- Identify a ‘ReSPECT Champion’ within their own organisation to become part of a local ReSPECT Champion Network that will meet quarterly to drive and further embed ReSPECT within the system.

- To ensure education and quality improvement in relation to the details on the ReSPECT form are a priority and that concerns regarding quality are raised via an appropriate platform to allow the system to work collaboratively to resolve in a supportive manner

- To work as one health and social care system by ensuring effective communication across organisations in relation to ReSPECT forms and shared decision making for the best interest of the patient

- Where necessary and appropriate, carry out those difficult conversations, and provide patients with the information they need to make decisions about their care

- Continue to explore digital options in alignment with the Doncaster Place Digital Strategy
- Acknowledge that ReSPECT recommendations can only be effective across healthcare settings if they are correctly completed and shared without delay with relevant healthcare professionals whose decisions it is intended to inform

7. Organisations that agree to the principles of this policy

- Doncaster Clinical Commissioning Group
- Doncaster Metropolitan Borough Council
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Primary Care Doncaster
- Doncaster Local Medical Committee
- Doncaster and Bassetlaw Teaching Hospitals
- Flyde Coast Medical Services – Doncaster
- Age UK Doncaster
- Yorkshire Ambulance Service

8. Review

This policy will be monitored for 12 months and reviewed as a system in April 2023.

9. Guidance and associated documents

https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/.

ReSPECT | Resuscitation Council UK

Mental Capacity Act 2005 (legislation.gov.uk)

Advance-Decisions-to-Refuse-Treatment-Guide.pdf (england.nhs.uk)

Advance care planning | End of life care | Royal College of Nursing (rcn.org.uk)

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in collaboration with ReSPECT Quality Improvement task & finish group
Feb 2022

Appendix 1

ReSPECT Operational Guidance for Doncaster & Bassetlaw Teaching Hospitals

Record Keeping and Communication

The flow of information and correct documentation is crucial to the success of this process. Whilst we are transitioning over to Version 3 of the ReSPECT form, all previously completed version 2 forms are still valid and do not need to be changed over unless the content is being updated. All newly completed forms should now be on version 3.

Where an individual may move care settings, including on discharge to the patient's own home, and the ReSPECT decisions have been reviewed and remain in place, the following core principles apply.

Whilst in Hospital

ReSPECT recommendations must 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). These are available pre-printed on WPR46732. All sections of the form must be completed and the circumstances surrounding the decision must be clearly stated together with who was involved in the decision making process. The information should also be evidenced with full and clear documentation in the patient's medical notes.

Nursing staff also have a duty to maintain up to date records of ReSPECT decisions including resuscitation status. Robust systems must be in place to ensure effective communication especially when a patient is moved between areas (e.g., ward to radiology).

To cancel a ReSPECT form, mark 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. The cancelled form should then be filed within the main body of the medical records.

On Discharge/ Transfer

On discharge, the form will follow the patient to their destination (this could be patients own home, nursing home or other care facility). On the day of discharge photocopy the form and write copy with the date and time at the top and place in the medical notes. The original must accompany the patient as they move between care settings (including the patient's home) and remain in their possession. The ReSPECT form should be placed in a clearly marked envelope and these are available pre-printed on WPR38411.

When a patient travels by ambulance, the discharging ward/department will give the envelope containing the original ReSPECT form to the ambulance crew who will formally hand-over the ReSPECT form to a member of staff receiving the patient, or to the patient/relevant others, on arrival at their destination.

It is an essential part of the discharge to inform the patient's GP that a ReSPECT form has been sent. Information about the ReSPECT decisions must be included in the discharge letter and communicated to the out of hours service as appropriate. This role may be delegated but is paramount to the communication process.

All other care providers such as carers, wardens and district nurses must also be informed about the ReSPECT decisions PRIOR to discharge. This role may be undertaken by the ward nursing staff or discharge coordinators as part of overall discharge planning.

Training/Support

The training requirements of staff will be identified through a training needs analysis. Once completed this training will be recorded on OLM/ESR. The following outlines the training for DBTH staff to meet the requirements of each tier of the locality training strategy.

Tier One

All DBTH staff already receive general awareness information about the ReSPECT process in the Resuscitation chapter of the SET booklet and have access to the appropriate links should they wish to view further information.

Tier Two

This is aimed at staff who are directly caring for patients. When ReSPECT was launched at DBTH in 2019, staff at this level completed an introductory e-learning package as well as receiving information via their annual resuscitation training sessions. This continues so compliance is achieved once staff attend their resuscitation induction or annual update. Further research is recommended but is individuals' choice.

Tier Three

Tier three training is aimed at staff who will be carrying out the ReSPECT conversation and completing the form. At DBTH this includes all medical staff, advanced care practitioners (including trainees) and specialist nurses who have completed these training requirements and have the full support of their immediate supervisors.

The expectation is staff complete **all** modules (40 mins) on the national ReSPECT webpage ReSPECT (respectprocess.org.uk). The ReSPECT Learning Web-application can be downloaded and used on mobile devices. Once completed a certificate is issued which must be sent to the Training Department dbth.training.department@nhs.net so compliance can be awarded on OLM/ESR.

In addition, workshops with table-top discussion and scenario/case base learning will be offered with an expectation that all staff in tier three attend at least one and further details of these will be circulated once enough staff have completed the above modules.

Consensus amongst all those involved in the ReSPECT process is the preferred aim but if consensus cannot be reached and the clinical recommendation is challenged, or an objection is raised, then a second opinion and/or legal review may be necessary. Please contact the Trust Patient Safety Team on dbth.risk.management@nhs.net for further advice and support.

A new network of ReSPECT champions is being developed across the locality to embed the policy, share learning, and generally support staff in the various settings. Further information on this will be shared via divisional governance and education leads in due course.

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in collaboration with Trust Patient Safety Committee
September 2022

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.2	Resuscitation Services	Nicola Vickers	Existing policy	October 2022

1) Who is responsible for this policy? Doncaster Health and Care Services Partnership

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 emergency care and 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

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

Date for next review: February 2025

Checked by: Juan Ballesteros **Date: October 2022**