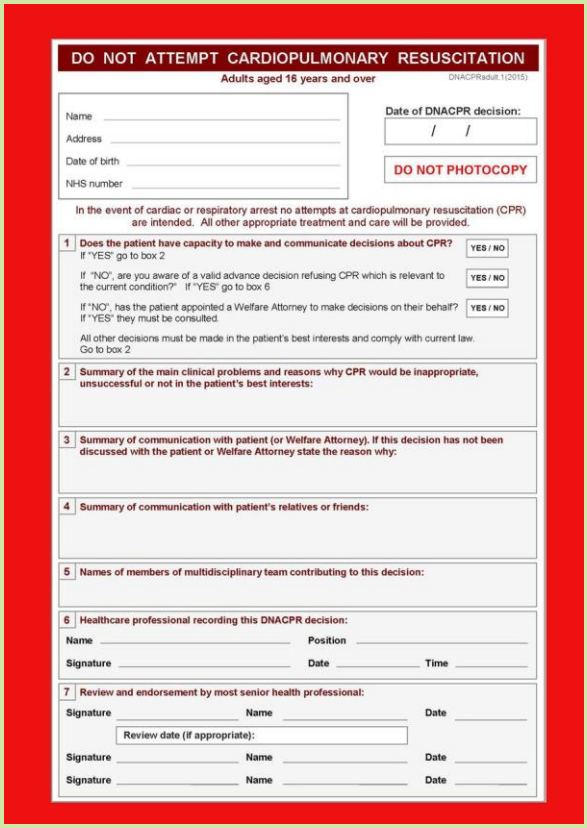
AmbuServ Ltd

To Resuscitate or Not?

If you have been involved in the healthcare sector in any way you will be aware of forms used by the NHS to advise you of when 'not to attempt resuscitation' on a patient and the legal implications of this action. Some of the issues, but not all, involved in the past have been:



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNACPRadult.1(2015)

Name

Address

Date of birth

NHS number

Date of DNACPR decision: / /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO
If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?* If "YES" go to box 6 YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. YES / NO

All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multidisciplinary team contributing to this decision:

6 Healthcare professional recording this DNACPR decision:

Name Position

Signature Date Time

7 Review and endorsement by most senior health professional:

Signature Name Date

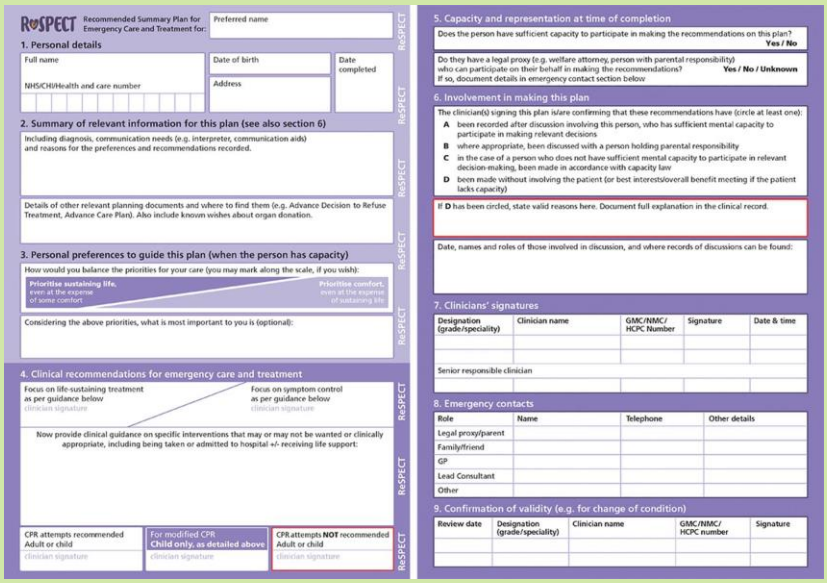
Review date (if appropriate):

Signature Name Date

Signature Name Date

- It's name; a DNR (Do Not Resuscitate), a DNAR (Do not Attempt Resuscitation), a DNACPR (Do not Attempt CardioPulmonary Resuscitation), an AND (Allow Natural Death) and other conurbations.
- Many patients would travel with, or hospitals and care homes would hold, photo copies.
- With all the different formats; it was very difficult to check the required details.
- Some forms did not include details of who the form had been discussed with or even if it had been discussed with the patient.
- Forms did not always explain why the requirement was nessarry.
- These forms would indicate a legal order i.e. 'DO NOT RESUSCITATE', in any circumstance; however, in reality it was a clinical recommendation.
- Confusion in the 'In force' dates or 'not for review' statement.

Over the last few years groups of experts have been responsible for reviewing this process and ensure the patient's wishes are very much the main focus of their care which includes whether CPR should or shouldn't be attempted. The Resuscitation Council (UK) and the ReSpECT Expert Working Group have developed the ReSPECT form, which addresses many of these issues. However, it would appear a great deal of the healthcare sector were unaware of the ReSPECT form or have very limited knowledge of it. Nurses within



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

Date of birth

Date completed

NHS/CHI/Health and care number

Address

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below

clinician signature

Focus on symptom control as per guidance below

clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child

clinician signature

For modified CPR Child only, as detailed above

clinician signature

CPR attempts NOT recommended Adult or child

clinician signature

ReSPECT

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? Yes / No

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? Yes / No / Unknown

If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

A been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions

B where appropriate, been discussed with a person holding parental responsibility

C in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law

D been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If D has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend			
GP			
Lead Consultant			
Other			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

the NHS were giving incorrect information to other healthcare staff. To understand the ReSPECT form better we requested a little clarity and Dr David Pitcher kindly responded on behalf of the Resuscitation Council (UK) and the ReSPECT Expert Working Group.

Following e-mail response received:

Your enquiry suggests that you may not be fully aware of the legal status of do-not-attempt-cardiopulmonary-resuscitation (DNACPR) forms that have been in widespread use. These make a **recommendation** that CPR is not attempted in the event of cardiac arrest. That recommendation is **not** legally binding. Unfortunately, the wording on some forms, and previously used terms such as 'DNACPR order' have tended to imply that this was a binding instruction rather than a recommendation. The final decision regarding whether or not to start CPR rests with the person or persons present at the time that a person dies or suffers sudden cardiac arrest.

The only legally binding document in this context (applicable only in England & Wales) is one in which the person has recorded a valid and appropriate advance decision to refuse treatment (ADRT), as defined in the Mental Capacity Act 2005.

The ReSPECT process and form differ from a DNACPR approach and form in that they firstly address a person's goals of care, then go on to discuss what care and treatments would help to achieve those goals and would be wanted, and what care and treatments the person would not want or would not work for them. The recommendations for care and treatment in an emergency are then agreed during this discussion and recorded in section 4, including a recommendation about CPR.

By signing the form in section 7 (as well as in the focus of care and CPR recommendation boxes) the clinician who has completed the form on the basis of such a discussion with the person (or with their family or other representatives if the person themselves lacks capacity) is confirming that they have done so in compliance with the law. If that clinician is not the senior clinician responsible for the person's care, their signature in section 7 is requested in order to ensure that they are aware of and agree with the contents of the form, but if that has not yet happened, it does not invalidate the agreed recommendations that were recorded.

In the context of your staff and the service that they provide, it is crucial that you have a policy in place that supports them in doing what is best for each individual in their care. Regarding CPR, if someone suffers sudden, unexpected cardiac arrest, has not expressed a wish not to receive CPR, and has no written recommendation about CPR, there would be a presumption in favour of attempting CPR for that person. In contrast, if there is a valid and appropriate ADRT refusing CPR they **must not** attempt it, and if there is a documented recommendation not to attempt CPR (on a ReSPECT form, DNACPR form or any other valid document), to ignore that recommendation and attempt CPR without very good reason would be difficult to justify, ethically or in law. An agreed recommendation not to attempt CPR may be made if:

- a person has expressed a wish not to receive CPR

- a person has an advanced illness from which their death is expected and CPR will not prevent their death
- it has been agreed that CPR is very likely to do a person harm and very unlikely to benefit them.

Understandably, health professionals (clinicians in various disciplines (including ambulance clinicians, nurses and doctors) will be more highly trained (and therefore better placed to make immediate decisions in an emergency) than non-clinicians such as many care home staff or first-aiders. Nevertheless, all those likely to be faced with making an immediate decision in an emergency should be supported by:

- a clear and robust policy that allows and encourages them to always act in a person's best interests and use all available information to guide their actions
- training in how to respond to any emergency that they are likely to encounter
- clear communication about the needs and wishes of each individual person in their charge.

We hope that ReSPECT will provide strong support for the third of these, but would emphasise that it is not a substitute for good communication between care providers at the time of handover of care (such as to or from a provider of transport).

Your final question related to section 9 and suggests that you may be looking at the ReSPECT form without referring to any of the supporting documents. This section is intended for completion only when there has been a formal review of the form and its contents (in discussion with the person or, if they lack capacity, their representatives) and their continuing relevance has been agreed. The form does not carry a review date or expiry date, as to do so would put people at risk. The requirement for review varies hugely among individuals. In an acute illness, the form may need at least daily review; at an advanced stage of a terminal illness there may be no need for review and to impose one could be intrusive or harmful.

I hope that this long response has provided some clarification. If there are any outstanding questions, please refer to the FAQs and other resources available on the ReSPECT website at www.respectprocess.org.uk, and let us know if these do not provide answers.

Yours sincerely
David Pitcher

Dr David Pitcher
on behalf of the Resuscitation Council (UK) and the ReSPECT Expert Working Group