



ReSPECT

Recommended Summary Plan for
Emergency Care and Treatment

NHS

Royal Berkshire
NHS Foundation Trust

ReSPECT and DNACPR

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DNACPR

- What do you know?
- How do you feel?
- What will make this talk useful?



Aims

- To briefly look at DNACPR and it's meaning
- To review some research on survival following cardiac arrest
- To understand how ReSPECT amplifies the patient voice.



What?

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Survival from Cardiac Arrest:

- Out of Hospital:
- 30-day Survival – overall
- England: 9.5%
- Northern Ireland: 6.5%
- Scotland: 9.6%
- In Hospital: 25.8% of patients survive to hospital discharge

Source: Epidemiology of cardiac arrest Guidelines. Authors: Christopher M Smith Sophie Skellett Jerry Nolan Gavin Perkins Jasmeet Soar

Adam Benson Clarke Published 27 October 2025



ReSPECT, DNACPR and the Law

Landmark cases:

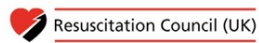
- 2014 High Court Judgement Tracey v University of Cambridge Health Trust
- 2015 High Court Judgement. Windspear v Sunderland NHS Trust
- Failure to discuss a DNACPR decision breaches the **Human Rights Act 1998 (articles 2 & 8)**
- ReSPECT is **not** legally binding. An ADRT is.



Decisions relating to cardiopulmonary resuscitation

Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing
(previously known as the 'Joint Statement')

3rd edition (1st revision) 2016



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Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time

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Who?

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Dr Matt Morgan



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Frailty and CPR outcome

RESUSCITATION PLUS 11 (2022) 100266

Available online at www.sciencedirect.com

Resuscitation Plus

journal homepage: www.elsevier.com/locate/resuscitation-plus

Clinical paper

Outcomes in adults living with frailty receiving cardiopulmonary resuscitation: A systematic review and meta-analysis

Joseph Hamlyn^a, Charlotte Lowry^a, Thomas A Jackson^{a,b}, Carly Welch^{a,b,}*

Clinical Medicine 2021 Vol 21, No 4: e357–62 ORIGINAL RESEARCH

Frailty, multimorbidity and in-hospital cardiopulmonary resuscitation: predictable markers of outcome?

Authors: Elin H Thomas,^A Aled R Lloyd^B and Nicky Leopold^C

Frailty is associated with adverse outcome from in-hospital cardiopulmonary resuscitation

Chris Wharton • Elizabeth King • Andrew MacDuff

Published: July 29, 2019 • DOI: <https://doi.org/10.1016/j.resuscitation.2019.07.021> •

JOURNAL ARTICLE EDITOR'S CHOICE

Frailty status predicts futility of cardiopulmonary resuscitation in older adults

FREE

Sarah E Ibitoye , Sadie Rawlinson, Andrew Cavanagh, Victoria Phillips, David J H Shipway

Age and Ageing, Volume 50, Issue 1, January 2021, Pages 147–152,



Conclusion

Patients with moderate or greater frailty as determined by CFS score are unlikely to survive to hospital discharge even if ROSC occurs following CPR. This should be considered when making resuscitation status and ceiling of care decisions in this patient group.

Conclusion

Frail patients are unlikely to survive to hospital discharge following in-hospital cardiac arrest, these results may facilitate clinical decision making regarding whether CPR may be considered futile. The Clinical Frailty Scale is a simple bedside assessment that can provide invaluable information when considering treatment escalation plans, as it becomes more widespread, larger scale observations using prospective assessments of frailty may become feasible.


Discussion: This review supports the consideration of frailty status in a holistic approach to CPR. The present findings suggest that frailty status provides valuable prognostic information and could complement other known pre-arrest prognostic factors such as comorbidities in the context of Do Not Attempt CPR consideration. Awareness of the poorer outcomes in those living with frailty could support the identification of individuals less likely to benefit from CPR. Validation of our findings and evaluation of quality-of-life in frail individuals surviving cardiac arrest are prerequisites for the future integration of frailty status into CPR clinical decision-making.

Conclusion Our findings suggest an association between increasing patient multimorbidity and frailty and poorer outcome post cardiac arrest.



Original research

Quality of life after in-hospital cardiopulmonary resuscitation for patients over the age of 80 years

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ABSTRACT

Objectives Success of in-hospital resuscitation decreases with age; however, national data show that 11.3% of patients over 80 years survive to discharge. There are few published qualitative data about the quality of life for these patients postsuccessful resuscitation. We aimed to investigate postresuscitation quality of life in patients over the age of 80 through a series of case studies.

Methods All patients over the age of 80 years, who received cardiopulmonary resuscitation (CPR) at our district general hospital in 2015–2016, were included. Success of resuscitation, survival at day 1 and to discharge were recorded. For patients who survived to 1 day and beyond, case reports were written to create individual patient stories.

Results 47 patients over the age of 80 years received CPR at Musgrove Park Hospital over a 2-year period. Five (10.6%) survived to discharge. Of those surviving to discharge, two had substantial functional decline, requiring discharge to nursing homes having previously been independent. Of the five families/patients who commented on their experience, only one expressed a positive view. When discussed, the majority of patients/families opted for a Do Not Attempt CPR.

Conclusion Our results have shown that there is a risk of substantial functional decline associated with successful CPR in these patients over the age of 80 years. The majority of patients and relatives contacted after successful resuscitation expressed a negative view of the experience. Our study highlights the importance of having early informed discussions with patients and families about CPR in order to avoid detrimental outcomes and ensure patient wishes are correctly represented.

INTRODUCTION

In order to make informed decisions regarding cardiopulmonary resuscitation (CPR), patients and teams need information about the likelihood of a successful outcome.

Receiving CPR when it is unlikely to be successful is a major concern expressed by patients approaching the end of their natural lives, and by their relatives.^{1,2} Moreover, prognostic information influences patient preference: fewer elderly patients wish to undergo CPR, once a clinician has explained the probability of survival.⁴

CPR becomes less likely to be effective with advancing age,^{3,5} but in the UK, the National Cardiac Arrest Audit data found that 11.3% of patients over the age of 80 survive to discharge after in-hospital cardiac arrest.⁶ In addition, some patients survive to 1-day postresuscitation but do not survive to discharge.

There are little published qualitative data on the quality of life for elderly patients who survive after CPR.⁷ We aimed to investigate postresuscitation quality of life in patients over the age of 80 through a series of case studies of all survivors of cardiac arrest in our hospital over a 2-year period.

Materials and methods

Data were collected at a large district general hospital over a 2-year period (2015–2016).

All inpatients over the age of 80 years who received external chest compressions, and were attended by the hospital-based resuscitation team in response to a 2222 call (the number commonly used by the UK hospital staff to summon an emergency care team), were included. This mirrors the scope of data collection used by the National Cardiac Arrest Audit.⁶ The rates of return of spontaneous circulation (ROSC), survival at 1 day and survival to hospital discharge were calculated. For those patients who survived to 1 day and beyond, case reports were compiled to create individual patient stories. Individuals and their next of kin were contacted and subjective opinions on the events collected. We asked the open question: ‘We wonder if you have any views about what happened to [you/their name of patient]’. Participants were invited to telephone or to use a printed reply slip ‘...to let us know anything you feel was important about [you/their name] experience, and that of [you/their] family’.

RESULTS

Forty-seven patients over the age of 80 received CPR at the Musgrove Park Hospital over a 2-year period (2015/2016). Five (10.6%) survived to discharge. Of this group, two had substantial functional decline, requiring discharge to nursing homes having previously been independent. A further 2 of the 47 patients (4.3%) survived to 1 day but not to discharge. We were able to gather information in person, by telephone interview or by written response. Comments were offered by patients/relatives of those of the five who survived to discharge, with two providing negative accounts of CPR, and one a positive account. Comments were received from relatives of the two patients who survived to 1 day but not to discharge, and both reflected negatively on the role of CPR.

Case studies 1–5: survival to discharge

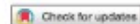
Case 1

An 86-year-old woman, previously independent at home, was admitted after resuscitation from an out-of-hospital cardiac arrest (OOHCA). Dilatated pulmonary embolism was diagnosed and she had a further pulseless electrical activity (PEA) arrest

Postgrad Med J: first published as 10.1136/postgradmed-2019-136565 on 13 September 2019. Downloaded from http://pmj.bmj.com/ on June 19, 2020 at Royal Berkshire NHS Foundation Trust. Protected by copyright.

Successful cardiopulmonary resuscitation (CPR) in those over the age of 80 years is associated with a risk of substantial function decline. It is important that medical practitioners and patients are aware of this to allow for informed decision-making around resuscitation status

This highlights the importance of having early informed discussions with patients and families about CPR in order to avoid detrimental outcomes to the patient and to ensure patients’ wishes are represented accurately



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When?

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How?

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What people need from a DNACPR decision and discussion

Findings from focus groups with older people.

When a clinician had made a decision not to attempt CPR and was communicating that decision, the key elements of a good conversation were:

- clinicians 'owned' the DNACPR decision
- clinicians explained why the decision had been made for that particular person, why CPR would do more harm than good, and what care and treatments the person would continue to receive
- clinicians explained that, while consent was not needed for the decision, they wanted to establish a shared understanding of how the person would be cared for
- people were invited to ask questions
- clinicians spoke with pragmatism and honesty
- clinicians showed sensitivity and spoke with warmth and respect

If you would like to know more about
ReSPECT, please scan this QR code:



For Royal Berkshire Hospital queries:

Patient Advice and Liaison Service (PALS) and Complaints exist to engage with patients, relatives and advocates who have complaints, concerns or enquiries. The team always try to resolve patient complaints or concerns promptly and effectively as informal concerns.

Contact

Contact **PALS** on 0118 322 8338 or PALS@royalberkshire.nhs.uk.



Questions?



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