

# ReSPECT form completion - A quality improvement project reviewing the accuracy and completeness of ReSPECT form documentation and DNACPR decisions

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## Background

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions are an integral aspect of many patients' hospital management plans. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms, implemented in 2014, aimed to improve patient/family involvement in end-of-life planning. They allow DNACPR decisions to be integrated within a holistic healthcare plan and provide patients with autonomy in managing their own health decisions. Incomplete or inaccurate ReSPECT form completion can compromise patient care and delay hospital discharges, leading to unwarranted interventions and/or unnecessary patient/family distress.

## Aims and Objectives

During a 4-month period, to produce a  $\geq 20\%$  improvement in both accuracy and overall completion of all sections within the ReSPECT form (Figure 1), with particular focus on DNACPR decision completeness. To educate ward doctors as to the intended aim of ReSPECT forms/DNACPR decisions, to empower colleagues to take personal responsibility in completion of forms. To report findings back to the QIP, palliative care and resuscitation teams to contribute to wider research.

## Methods

Over a 4-month period (21/12/21-29/4/22), ReSPECT forms for each respiratory ward inpatient at Doncaster Royal Infirmary (DRI) were regularly reviewed. Prior to starting any PDSA cycle intervention, 2 weeks of baseline data was collected. Three interventions (a presentation delivered to junior doctors, a ward poster and a different presentation emailed to consultants) were then implemented over 11 data collection points (Figure 2), reminding doctors to check ReSPECT forms and rectify errors or missing sections. Data analysis used run charts to assess if any intervention correlated with more complete or accurate documentation.

## References

- Resuscitation council Website ReSPECT | <https://www.resus.org.uk/respect>
- BMJ paper Resuscitation policy should focus on the patient, not the decision BMJ 2017;356:j813 doi: 10.1136/bmj.j813 (Pub 28 Feb 2017)

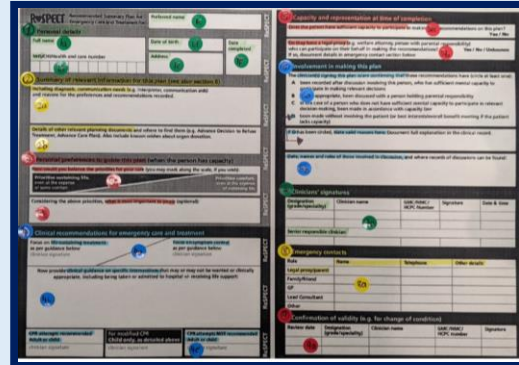
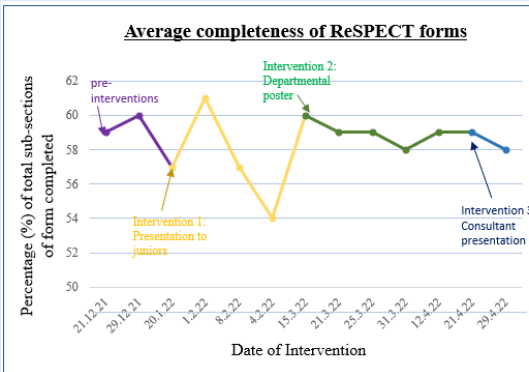
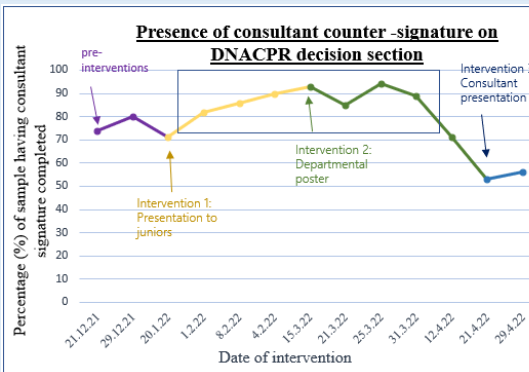


Figure 1: Demonstration of ReSPECT form subdivisions used to analyse subsections during data collection



Graph 1: Overall average completeness of ReSPECT forms



Graph 2: Documented consultant counter-signature for DNACPR decision in signature section of ReSPECT form

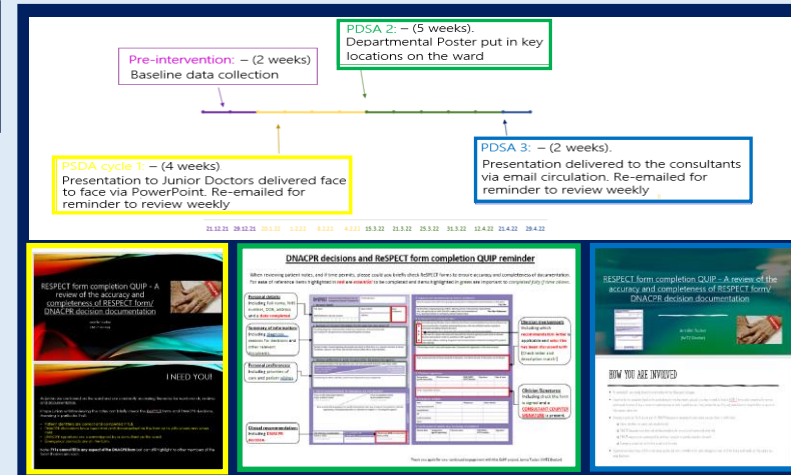


Figure 2: Run chart showing all PDSA timescales and illustrations of each intervention delivered. Intervention 1: presentation delivered to junior doctors (yellow); Intervention 2: ward poster (green); Intervention 3: alternative presentation e-mailed to consultants (blue).

## Results

Pre-intervention data recorded correct completion of full name details in 95% of cases. Throughout all 3 intervention stages, full names were documented accurately in 100% of forms, a sustained 5% improvement from baseline. Throughout 13 weeks of data collection, there was no significant improvement seen in overall completeness of ReSPECT forms during any intervention phase (Graph 1). There was poor documentation of patient preferences as to their priorities of care, with no intervention increasing completion above 30%. Both pre-intervention and throughout all 3 interventions there was 100% documentation of CPR or DNACPR decisions. However, there were often inconsistencies when recording details of the people this decision was discussed with, which were not significantly improved by any of the 3 intervention stages. In seven consecutive data collection points, there was a temporary improvement (from baseline) in the percentage completion of consultant counter-signed DNACPR decisions. This was observed after delivering junior doctors' presentations and developing a ward departmental poster (Graph 2). However, this improvement was not sustained for the duration of an entire intervention stage.

## Conclusions and Discussion

This QIP demonstrated small improvements in patient name documentation and a temporary improvement in consultant counter-signatures on ReSPECT forms. However, no interventions produced sustained improvements in either completeness or accuracy of ReSPECT form documentation overall or for any individual section. Despite not achieving its aims, this project highlights that ReSPECT forms aren't currently used as intended, documenting simply a DNACPR decision rather than a holistic care plan. Project limitations include the small sample size, potential for data collection bias (collectors working on ward) and project time constraints. More research is required, but this data has contributed to broader ongoing research by palliative and resuscitation teams to improve DNACPR and ReSPECT form completion.