HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

554 – MANAGEMENT OF CASES WHERE WOMEN CHOOSE TO DECLINE CARE AS RECOMMENDED BY THE HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST MATERNITY GUIDELINES

Broad Recommendations / Summary

For quick reference the guide below is a summary of actions required to ensure appropriate implementation of this policy / procedure / guideline. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy / procedure / guideline.

Hull University Teaching Hospitals NHS Trust is committed to providing patient centred care, ensuring consistency in delivering high quality safe care to all women and their babies and focusing upon meeting the individual needs of women and their families. The staff act with integrity, compassion, sensitivity and kindness at all times when providing care and work in partnership with women, their families and other health care providers.

A pregnant woman with capacity can refuse treatment/decline care, even if that refusal may result in harm to her or her unborn child. Staff have a responsibility to ensure that a woman is provided with sufficient information in order to decide for herself whether or not to accept treatment and also to ensure that we know how to proceed in such a situation.

When a woman chooses to decline care that is recommended by the Hull University Teaching Hospital NHS Trust maternity guidelines, this guideline should be used to support the development of an individualised plan of care that is well documented and shared with the woman and members of the multidisciplinary team in order to support her care.

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1 PURPOSE / LEGAL REQUIREMENTS / BACKGROUND

- To standardise and optimise the care and safety of women and their babies when they chose to decline the care recommended by the Hull University Teaching Hospitals NHS Trust maternity guidelines
- To ensure all staff understand their role and responsibilities in supportive care
- To support staff in providing care to women who decline care recommended by the Hull University Teaching Hospitals NHS Trust maternity guidelines
- To support staff in documenting discussions with the woman, aid consideration of all factors and also to allow clear documentation of the woman's wishes

2 POLICY / PROCEDURE / GUIDELINE DETAILS

What to do when a woman wishes to decline care recommended by Hull University Teaching Hospitals NHS Trust guidelines in the antenatal period, when there is NO URGENCY to her decision

Make an appointment for the woman in the antenatal clinic (ANC). Ideally present at this appointment along with the woman should be a consultant obstetrician, senior midwife and any further health professionals whom are deemed necessary for the woman's care e.g. anaesthetist, screening midwife.

In the event of members of the multi-disciplinary team not being present at the appointment the plan of care must be shared with the appropriate members of the team following the appointment as detailed below.

Consider whether the woman's case will need to be discussed in a multi-disciplinary forum.

If the woman declines an appointment in the ANC, offer to arrange an appointment in the woman's home with a second midwife present. The outcome of this meeting should be shared in the same manner as the outcome of an appointment in the ANC.

Aim for at least two appointments of this nature during the antenatal period to include a birth planning meeting at approximately 36 weeks gestation.

The frequency of these appointments will be tailored to the woman's individual needs.

Together with the woman, complete the 'Choice outside of guidance pro-forma' (see appendix 1) ensuring that you understand and document exactly what she is declining and the reason she gives for this. Consideration should be given to safeguarding issues, religious beliefs, coercion, phobias and the woman's mental health.

You must presume that the woman has capacity but perform an assessment of capacity as soon as possible (see appendix 2). Fully explore all the relevant risks to the woman and fetus in a reasonable, non-threatening and evidence based manner.

Explore any suitable alternatives to the treatment being declined. If the woman still declines treatment, acknowledge that this is her choice and engage with her to agree a plan of care going forward.

Provide clear information for what action the woman should take, should she change her mind or require assistance in an emergency.

Should the woman continue to decline care, you should revisit the pro-forma (appendix 1) and perform an Assessment of Capacity, documenting the outcome, at every contact.

A copy of the completed pro-forma must be placed in the hand held antenatal records, in the hospital maternity records, and also in Lorenzo under 'clinical notes' along with any relevant referrals as an outcome; for example to social services, the woman's GP, police, perinatal mental health services.

In addition, evidence of the appointment and agreed action plan will be formally documented in a letter and distributed to the woman, her GP, her community midwifery team, her named consultant and the labour ward matron. These can then be distributed further if necessary e.g. to midwifery managers or labour ward practitioners. A copy of this letter must also be placed in the hand held antenatal records, in the hospital maternity records and also in Lorenzo under 'clinical notes'.

Should the woman change her decision at any point and accept the care she previously declined, this should be documented clearly and all care providers made aware of this.

Advice and support can be accessed by any midwife from the Professional Midwifery Advocate team.

What to do when a woman wishes to decline care recommended by Hull University Teaching Hospitals NHS Trust when presenting in labour or if an EMERGENCY/ URGENT intervention is required in the antenatal period when no prior discussion has taken place

Clarify exactly what the woman is declining and if possible the reason why giving consideration to safeguarding issues, religious beliefs, coercion, phobias and the woman's mental health.

Explore any suitable alternatives to the treatment being declined.

Fully explain in a reasonable, non-threatening and evidence based manner, all of the risks to the woman and fetus which may materialise if the woman declines.

If the woman continues to decline you must presume that she has capacity but arrange for an assessment of capacity to be performed by a consultant obstetrician. Contact the obstetric consultant on call immediately and request that they come in to perform an assessment of capacity as a matter of urgency.

Inform the Labour Ward Co-ordinator immediately.

Whilst awaiting the consultant on call, two senior obstetric doctors (if available) should each perform an assessment of capacity as a matter of urgency. The assessment should be clearly documented in the notes along with the doctors' conclusions.

If the doctors deem the woman to have capacity, they should continue to respect the woman's wishes and record these. However, they should also ensure that they advise the

woman of any changes in condition or level of risk/injury to her or the fetus to allow her the opportunity to change her mind.

If the doctors deem the woman not to have capacity, they should await the arrival of a consultant on call or in an emergency situation follow the 'Mental Capacity Act, Deprivation of Liberty Safeguards, Consent and physical restraint policy' on Pattie.

If the woman usually has capacity but is temporarily thought to be incapable, the law permits interventions to be made which are necessary and no more than is reasonably required in the best interests of the woman pending the recovery of capacity. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and can consent to (or refuse) the intervention, it must be delayed until that time.

If however the consultant deems the woman to have capacity, they must respect the woman's wishes and record these. However, they should also ensure that they advise the woman of any changes in condition or level of risk/injury to her or the fetus to allow her the opportunity to change her mind.

Consider referrals to appropriate services, as listed above, in a timely manner.

ReSPECT

In some circumstances it may be appropriate to consider the use of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documentation alongside the Choice outside of guidance proforma (Appendix 1). See further guidance via CP389 ReSPECT Policy- Adults [redacted] and appendix 3 – ReSPECT form.

3 PROCESS FOR MONITORING COMPLIANCE

Three yearly review and renewal of document

4 REFERENCES

- Mental Capacity Act, Deprivation of Liberty Standards, Consent and Physical Restraint Policy [redacted]
- Self-Discharge Refusal of Treatment Against Medical Advice Policy [redacted]
- Department of Health (1983) Mental Health Act 1983: Code of Practice (Revised 2007) London: DH
- Department of Health (2005) The Mental Capacity Act 2005 (Revised 2007) London: DH
- General Medical Council, Consent: patients and doctors making decisions together (2008) GMC: London. (www.gmc-uk.org)

5 APPENDICES

- Appendix 1 – Choice outside of guidance proforma
- Appendix 2 – Information about capacity
- Appendix 3 – ReSPECT form

6 DOCUMENT CONTROL

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Version Control			
Date	**Version**	**Author**	**Revision description**
October 2018	V1	[redacted]	New guideline
January 2022	V2	[redacted]	Review and renewal

Appendix 1 – Record of a discussion surrounding informed choice of treatment and care.

All adult women are presumed to have capacity to make decisions about their clinical care (appendix 2).

In the event that uncertainty about capacity arises, a second opinion must be sought and all 3 criteria must be met:

1.1 The patient is able to understand and retain information related to the treatment proposed, its indications, main benefits, risks and consequences of non-treatment

1.2 The patient can be shown to believe the information

1.3 The patient is able to weigh up the information in order to arrive at a conclusion without duress

Does the patient have capacity **Yes / No**

2. Are there any barriers to language and understanding? Address these before continuing discussion.

3. Who is present in this discussion?

4. What treatment and care or choice of birthplace / method does this conversation relate to?

5. What is the woman's view of the proposed plan of care and what is her preferred plan?

6. Are there clinical contraindications to this plan?

7. Are there safeguarding concerns? If so please follow trust guidance. Does the plan relate to religious beliefs?

8. If plan relates to mental health concerns, is there a PNMH plan?

9. Has a balanced discussion of risk and benefit been undertaken? Are there areas of mitigation? Please list risks and where appropriate actions to mitigate risks, or acknowledgement of risk by woman.

10. **Advice provided to the patient**

10.1 Signs and symptoms to be aware of and when to seek medical attention if appropriate:

_____

_____

_____

10.2 What action to take, should you change your mind / plan or require assistance in an emergency.

_____

_____

10.3 What to do if assessment/ different treatment is subsequently required:

_____

10.4 Self-management advice/patient information leaflets given:

_____

11. Patient declaration I, the undersigned, have participated in the above discussion and am happy that it is a true reflection of the discussion.

Patient Signature _____Name _____Date _____

Midwife/Doctor

Signature _____ Name _____ Date _____

Other professionals present

Signature _____ Name _____ Date _____

Other professionals present at discussion

Signature _____ Name _____ Date _____

Appendix 2 – Information about capacity

There is a presumption that every adult has the right to decide whether he/she will agree to examination, investigation or treatment unless and until the presumption is refuted. This applies even if by refusing they may risk permanent injury to their health or death. A healthcare provider must respect a patient's decision to refuse treatment, even if they think their decision is wrong or irrational.

However, the trust has the responsibility to ensure that patients are provided with sufficient information in order to decide for themselves whether or not to accept medical advice and also to ensure that staff know how to proceed when dealing with a patient who refuses essential medical treatment.

A competent pregnant woman has the right to refuse treatment even if that refusal may result in harm to her or her unborn child as per St George's Healthcare NHS Trust v S;R v Collins and others, ex parte S (1998) 2 All ER 673.

The only exception to this is if the woman is assessed and deemed not to have capacity.

- **Adults are presumed to have capacity to refuse medical advice and treatment.**
- **The burden of refuting the presumption lies with those wishing to treat a non-compliant patient.**
- **A patient may retain capacity even if detained under the Mental Health Act 1983.**

<u>Determining capacity</u>
A patient lacks capacity only if some impairment or disturbance of mental functioning renders him/her unable to decide for themselves whether to consent to or refuse treatment.

To have capacity to refuse, a patient must:

- Understand information about the decision to be made (relevant information)
- Retain that information in their mind
- Use or weigh that information as part of the decision making process
- Communicate their decision (by talking, using sign language or other means)

An assessment of capacity must take into consideration the effect physical as well as mental illness may have on the patient's ability to demonstrate capacity, e.g. the effect of drugs, alcohol, physical injury such as a head injury etc. In these circumstances consider whether it is likely that the person will at some time have capacity in relation to the matter in question and if so, when that is likely to be.

Further information regarding capacity can be found in the Hull University Teaching Hospitals NHS Trust Guideline CP258 – Self discharge/refusal of treatment against medical advice.

Appendix 3 – ReSPECT form

ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

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	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

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 (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.

☐ **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, 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/other			
GP			
Lead Consultant			

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

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