University Hospitals of Derby and Burton
NHS Foundation Trust

TRUST POLICY FOR RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT (ReSPECT) FOR ADULTS

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	1.0	February-April 2018	David Jones	New policy
	2.0	October 2020	David Jones	Revised in light of new process
	2.1	September-November 2023	David Jones Dr R Aldridge	Review - minor amendments

Intended Recipients: All clinical wards and departments

Training and Dissemination: Implementation of ReSPECT Trust Implementation Group Plan. To be then included in all Resuscitation Mandatory Training, which includes Induction for clinical staff.

To be read in conjunction with:

- Consent including the Mental Capacity Act (Lawful Authority for Providing Examination, Care or Treatment) - Trust Policy and Procedures
- Resuscitation - UHDB Trust Policy and Procedure

In consultation with and Date: UHDB ReSPECT Group - 14 November 2023

EIRA stage One Completed Yes

stage Two Completed No

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Contact for Review	Dave Jones – Resuscitation and Clinical Skills Manager
Executive Lead Signature	 Gis Robison, Interim Executive Medical Director

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1. Introduction

The Trust has adopted the national ReSPECT process and has agreed to use the latest version of the national ReSPECT form, which should be used across all care settings.

On-going developments and continuous improvements in health care mean that many people are able to live well, for longer than ever before. For the vast majority, the over-riding aim of care and treatment in an emergency situation is to return them to their pre-emergency level of health, or as near to that as possible.

However, recent advances cannot extend life, or stave off ill health, indefinitely. Many people want to be able to influence the treatment 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.

Cardiopulmonary resuscitation (CPR) is one treatment that has received much attention, and that has undoubted potential benefits for some people. However, for many people, CPR will have minimal or no chance of success, and provide no benefit, to the person receiving it. Other people may make an informed decision that they do not wish to receive attempted CPR should they suffer cardiorespiratory arrest, even if it might have a good chance of success / benefit in their situation.

Recent attention has also been given to treatments other than CPR that may be relevant when people are seriously ill. Recommendations about whether these treatments should or should not be given to a person are often referred to as 'emergency treatment plans' or 'treatment escalation plans' as they concern decisions regarding the appropriateness for each individual of starting or not starting, continuing or not continuing, certain treatments. These treatments may include for example, clinically assisted hydration or nutrition, assisted ventilation, or intravenous antibiotic therapy.

Decisions about whether or not to initiate CPR are one element of these 'emergency treatment plans'. Decisions about CPR and other emergency treatments are often made as part of the process of 'advance care planning': a process through which people who are able to can express their preferences and plan for their future care, and are helped and supported to do so, in anticipation of a time when they may be unable to participate in decision-making about the care that they receive.

Increasing evidence suggests that considering whether or not to attempt CPR and discussing CPR in the context of overall goals of care and other types of care and treatment that might be needed reduces incidences of harm compared to focusing only on "CPR not recommended" decisions and where harm does occur it is less severe.

Several factors are important to consider when these decisions are made. These include the chances of the treatment in question being successful; the wishes, beliefs and values of the person who would like to receive, or not to receive, a particular treatment; the ability (mental capacity) of the person to make decisions about their care; any legally binding refusals of treatment that they may have made, or the views of proxy decision-makers who have been appointed to act on the persons behalf.

Documented evidence of a person's choices or wishes is especially important and helpful to those who have to make decisions about potentially life-sustaining

treatments. Many decisions that relate to emergency treatment need to be taken with urgency, often in a significant situation where a person lacks mental capacity to make or contribute to making decisions at that particular time. Knowing what a person would have wanted to happen to them keeps them at the centre of care, even when they may not be able to make their wishes known.

2. Purpose and Scope

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process has been developed since October 2014, by a UK-wide group, which has been facilitated by the Resuscitation Council UK and the Royal College of Nursing. Its development was initiated following a systematic review of DNACPR decision-making and in the light also of the NCEPOD 'Time to Intervene' report (2011), the Court of Appeal judgement in the case of The Queen on the application of David Tracey vs. Cambridge University Hospitals NHS Foundation Trust and others ('the Tracey case'), the national guidance Decisions relating to Cardiopulmonary Resuscitation (BMA, RC UK, RCN, 2014) and a growing demand for a national form for recording anticipatory recommendations about CPR and for a treatment-escalation-plan-style document.

ReSPECT is a process, the aims of which are to promote constructive conversations between people and their clinicians about planning for future emergencies, to encourage 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. The ReSPECT process and documentation can be initiated and completed in any healthcare setting (acute, hospice or community); it can be shared between settings, and be valid across all of them to ensure best care for the person wherever they may be.

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).

Purpose

- To support the implementation of the ReSPECT document across all healthcare settings, this Policy should be read as integral to the use of that document
- To acknowledge the centrality of people in decisions about the treatment that they receive, and to support shared decision-making between people and those providing care and treatment to them
- To support advance care planning for those who choose to participate in this process, whether or not they have an advanced or progressive illness
- To support the right of people aged 18 years and above to refuse, in advance, any treatment, even if that treatment is potentially life-sustaining. This right applies to adults with the mental capacity to refuse treatments in advance, in line with existing legislation
- To support the legal requirement to treat those who lack mental capacity in relation to a particular decision, in their best interests. This extends to making decisions about potentially life-sustaining treatments on behalf of a person, including decisions about cardiopulmonary resuscitation (CPR)
- To provide a framework that guides healthcare professionals and providers, people, families and carers in making decisions and recommendations about potentially life-sustaining treatments, in line with good clinical practice and legal requirements

- To make clear the legal status of a completed ReSPECT document
- To support the use, transfer and acceptance of the ReSPECT document across organisational and geographical boundaries, accompanying the person and applying in all settings
- To support the use of the ReSPECT document as a summary of recommendations to guide immediate decision making in an emergency only. It is not as a replacement for more detailed advance care plans or for comprehensive documentation including details of discussions that have taken place. Such discussions must be documented in the relevant health and care record
- To provide a policy that can and should be tailored to local healthcare governance processes and procedures, in such a way that maintains its substance. To provide a policy that complements, rather than duplicates, existing relevant local healthcare policies and procedure. This policy supports fully the national guidance on CPR decisions published by the British Medical Association, the Resuscitation Council UK and the Royal College of Nursing (2016) and the latest General Medical Council guidance (2010). This policy should be read in conjunction with that guidance. This policy does not provide a guide to completing the different sections of the ReSPECT document; that guidance is contained within 'A Guide for clinicians completing the plan' (appendix 2).

Scope

This policy applies to all the multidisciplinary health and care teams involved in a person's care in all settings and is applicable to people aged 18 years and over.

The ReSPECT document:

- Is relevant to decisions relating to other emergency and potentially life-sustaining treatments, such as clinically assisted hydration and nutrition, assisted ventilation and intravenous antibiotic therapy (this list is not exhaustive) as well as cardiopulmonary resuscitation (CPR)
- Is intended to be transferable between, and valid in, all health and care settings, to avoid duplication, and to ensure that the person remains at the centre of decision-making wherever they may be
- Is applicable to all adults, whether or not they have an existing illness, or an advanced, progressive illness
- Does not remove the need to record discussions and rationale for decision-making in a person's current health record, in line with local procedures. Rather, the ReSPECT document is a summary document that facilitates recording and sharing of important information, and immediate clinical decision-making in a crisis
- Is intended to replace forms currently in use to record DNACPR decisions
- Does not constitute a legally binding refusal of treatment. It should be used as a guide to best-interests decision-making by healthcare professionals in an emergency setting, in relation to potentially life-sustaining care and treatments. As such, where it records the person's express preferences for their future care and treatment, it constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'advance decision to refuse treatment (ADRT)'
- Is intended to remain with and to be held by the person, and may be transferred also between any health and care professionals involved in a person's care. Please note that a paper ReSPECT document should be treated as the active and current version of that document.

Definitions Used

Advance Care Planning (ACP)	A voluntary process through which people can make decisions, or engage in planning about the care that they may be offered at a time when they lack capacity to give or withhold consent. ACP may take the form of stating wishes, preferences and values in an 'advance statement', and may include (in England and Wales) a legally binding refusal of a specific treatment. As such, it is broader than, but includes, 'emergency treatment planning' (see below). Please refer to the Mental Capacity Act 2005, and local policy, for further information.
Advance Decision to Refuse Treatment (ADRT)	A legally binding decision means (in England and Wales) through which a person aged 18 years and above, who has capacity to do so, may at that time. To be valid, an ADRT must meet specific criteria. Please refer to the Mental Capacity Act 2005, and local policy, for further information.
Advance Statement	This is not defined in the Mental Capacity Act 2005 but is understood as an expression of a person's wishes, beliefs, values, or other information, that must be taken into account when decisions are being taken on behalf of a person who lacks mental capacity. Please refer to the Mental Capacity Act 2005, and local policy, for further information.
Best Interests	An objective measure of overall benefit to a particular person. Under the Mental Capacity Act 2005, decisions made on behalf of people who lack mental capacity to do so themselves, must be made in their 'best interests'. This process includes consideration of the past and present wishes, feelings beliefs and values (and any other factors that he / she is likely to consider if able to do so) of the person, and consultation with specified classes of person as set out in the Mental Capacity Act 2005. Please refer to the Mental Capacity Act 2005, and the Trust's Mental Capacity Act 2005 Best Interest Checklist.
Cardiopulmonary resuscitation (CPR)	A term which refers to attempts made to restart the heart and provide breathing for a person in cardiorespiratory arrest. The chances of success vary, depending on several factors including the cause of the arrest and any underlying illness that the person may have. In English law, CPR is classed as a medical treatment.
Cardiorespiratory Arrest	The cessation of cardiac output and spontaneous breathing, inevitably leading to death.
Consent	The process by which a person, with the mental capacity to do so accepts a treatment that is offered to them. To be valid, consent must be given freely, and be based on adequate information. Please refer to GMC guidance on consent and local policy for further information.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision	A 'decision' that CPR should not be attempted for a particular person. It is clinicians who must make the decision whether or not to attempt CPR. Such recommendations must be made in accordance with legal requirements, should follow good clinical practice and should be documented clearly and correctly.
Emergency treatment decisions	The term often given to decisions about providing or limiting potentially life-sustaining treatments for a given person. Anticipatory decisions / recommendations about CPR are an example of emergency treatment planning. (See glossary entry for 'emergency treatment plans', below).
Health records	Often referred to as 'medical notes' or 'patient notes', a person may have separate health records in different places of care. For example, a health record may be the GP's records for a person at home, or the hospital's 'medical notes' when the person is in hospital. The increasing use of digital records that are interoperable can facilitate transfer of information between different sets of records.
Lasting Power of Attorney (LPA)	LPA can be given only by people aged 18 years and above. A person given this power under the Mental Capacity Act 2005, (the donee) has the power and responsibility to make certain decisions on behalf of a person (the donor). Only if an LPA gives decision- making power relating to 'health and welfare' can the donee make decisions about a person's care and treatment. The donee can make decisions about life sustaining treatment such as CPR only if the LPA document states this specifically. In order to be valid, an LPA must have been registered with the Office of the Public Guardian, applicable to the relevant decision and (for health and welfare decisions for themselves at the time it must be made. Please refer to the Mental Capacity Act 2005).
Mental Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. A person with mental capacity can understand and retain the information relevant to the decision in question, weigh it up, and communicate their decision by any means. Please refer to the Mental Capacity Act 2005, and local policy, for further information. The Mental Capacity Act 2005 applies to people age 16 years and above.
Potentially life-sustaining treatment	Any medical treatment that, in the judgment of the healthcare professional with overall clinical responsibility for a person, has a significant chance of sustaining a person's life in a life-threatening situation. This may include CPR, clinically assisted hydration and nutrition, assisted ventilation and intravenous antibiotic therapy (this list is not exhaustive).
Provider organisation / healthcare provider organisation	This is a broad term that refers to the organisations and institutions responsible for the provision of health care to a in any setting. It includes, for example, hospitals, ambulance services, and General Practices.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document	The document supported by this policy. The ReSPECT document summarises information and recommendations about emergency care and treatment for a person in the event of their clinical deterioration and them having a lack of capacity at that time. The document records recommendations about potentially life-sustaining treatments for a person, including a recommendation about CPR.

3. Key Responsibilities / Duties

3.1 Consultants

The overall clinical responsibility for decisions about ReSPECT and CPR rests with the Consultant in charge of the patient's care. If the decision is made by a doctor in training, the Consultant must be informed at the earliest opportunity and then sign section 7 of the ReSPECT form.

3.2 Doctors in Training

In situations where a discussion surrounding ReSPECT takes place by a pre-registration Foundation Year 1 (FY1) doctor with a patient, relative, carer or Independent Mental Capacity Advocate (IMCA), the FY1 doctor must refer to a more senior colleague on duty who must be FY2 level doctor or above, who would commence the decision-making process and complete a ReSPECT document.

3.3 Advanced Clinical Practitioners, Clinical Nurse Specialist and Senior Sister / Charge Nurses in Community Hospitals

Decisions on ReSPECT can also be made by an appropriately trained Advanced Clinical Practitioner, trainee Advanced Clinical Practitioner, Clinical Nurse Specialist and Senior Sister / Charge Nurses in Community Hospitals, who has undertaken training and assessment which is delivered by the Trust. It is recommended that this staff group should have successfully undertaken Tier 3 communication skills training. All ReSPECT decisions made by an Advanced Clinical Practitioner or Clinical Nurse Specialist must be discussed with the patient's own Consultant,
Specialist Trainee (ST3) or above, or GP, as part of the decision-making process. (see appendix 2) This consultation must be clearly documented on the ReSPECT document and the Consultant must sign the form at the earliest opportunity.

3.4 Clinical and Ward Staff

Decisions about ReSPECT can be reviewed especially whenever changes occur in the patient's condition or in the patient's expressed wishes. Reviews can be during ward rounds or by request to medical staff by staff responsible for the patient's nursing care. If there are any subsequent changes in the decision the patient should be consulted about the decision and the reason for any change.

3.5 Trust ReSPECT Group

It is this Groups responsibility to continue to develop and monitor the compliance with the policy and ReSPECT document and report to the Trust's Patient Safety Group.

4. Who should have a ReSPECT Document?

The ReSPECT document addresses emergency care and treatment planning in relation to emergency and potentially life-sustaining treatment, including CPR. It should be considered for, but not limited to, those who are at risk of a significant clinical deterioration that may place their life at

risk. Such people may already have an existing illness, such as advanced organ failure, or advanced cancer. As a minimum, it should be considered for any person that is at foreseeable risk of cardiorespiratory arrest, as is currently recommended for anticipatory decisions about CPR.

A person's wishes may lead to a ReSPECT document being considered, discussed and completed even in the absence of advanced illness. Furthermore, a ReSPECT document may be of benefit to a person who is at risk of a sudden incapacitating illness, to record elements of care and treatment that should be considered for them in such a situation.

4.1 Making Clinical Decisions in an Emergency Situation

The clinical responsibility for making emergency treatment decisions, including those in relation to CPR, rests with the most senior healthcare professional attending the person at the time that a decision must be made. This may be any doctor of FY2 level and above, ACP (trainee) or Clinical Nurse Specialist with the appropriate knowledge and skill to make these decisions, who have successfully undertaken ReSPECT training. **Decisions must always be made in accordance with existing legal requirements, with good clinical practice, and with local policy.**

In the absence of a legally valid and applicable ADRT that refuses the treatment in question (including CPR), a decision must be taken in the best interests of the person whose treatment is being considered, if the person is unable to or does not wish to engage in discussions regarding treatment options. In this situation a completed ReSPECT document is an aid to such decision-making. In the case of uncertainty there should be a strong, but not absolute, presumption in favour of providing treatment that is potentially life-sustaining. If in doubt, and the clinical situation allows, obtaining advice from a senior healthcare professional, from other healthcare professionals involved in the care of the person and from those close to the person (such as family or friends) should be attempted to ascertain what the wishes of the patient may have been, in line with legal requirements as stipulated in Section 4(6) and 4(7) of the Mental Capacity Act 2005 (see below).

4.2 Communication and Discussion Concerning Decisions about Potentially Life-Sustaining Treatments

A Consultant, GP or their nominated deputy should use their clinical judgement about initiating discussions about CPR and other emergency treatment decisions. There must be a presumption in favour of discussing these issues with people over the age of 18 years who have the mental capacity to participate in such decision-making, and the threshold for not doing so is set high (i.e. a risk of physical or psychological harm to the person from having the discussion). This applies even if CPR is thought to have little or no chance of a successful outcome.

A healthcare professional has no legal duty to give a person a treatment that they judge to have no reasonable chance of success, or to be clinically inappropriate, including CPR. Furthermore, the national guidance on CPR decision-making recommends that where treatment has no realistic prospect of benefit, it should not be offered. In such circumstances the presumption in favour of involving the person is considered to require careful and sensitive explanation of their condition and of the reasons why a treatment would not work or would be inappropriate in their situation.

Although recent case law refers principally to DNACPR decisions, the 'duty to consult' is recognised as a fundamental aspect of health care in relation to other treatments, and should be viewed as applying to decisions about other potentially life-sustaining treatments. If there is a realistic chance that CPR would be successful, and the person has capacity, then the person must be involved in considering and making plans and recommendations concerning whether or not CPR should be attempted.

If neither the person nor those close to him / her has been involved in decision-making, the reasons should be recorded clearly on the ReSPECT document and in the person's current health record. Such situations will present significant challenges to the provision of person-centred care, especially in a community setting. Care should be taken when considering whether, or how, to transfer a ReSPECT document or information relating to the challenges experienced, across settings.

4.3 ReSPECT for people with mental capacity to make decisions about care and treatment in emergency situations

Any person over the age of 16 years can give or withhold consent to any treatment offered to them, if they have the mental capacity to do so, so long as their decision is voluntary and adequately informed. This applies even if a decision concerns whether or not to undergo treatment that is potentially life-sustaining.

Advance care planning, and emergency treatment planning using the ReSPECT process and documentation, can be valuable to guide the future care of such people. The healthcare professional with overall clinical responsibility for a person is responsible for ensuring that there are no doubts as to the mental capacity of the person participating in shared decision-making in relation to potentially life-sustaining treatments, including CPR. If an assessment of mental capacity is needed, this can be delegated to a nominated deputy with the knowledge and skills to fulfil that role.

4.4 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 about types of emergency and potentially life-sustaining treatment, including CPR, for people who lack the mental capacity to discuss and make informed, shared decisions about these recommendations.

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 age 16 years and over. The Act sets out five 'statutory principles' – the values that underpin its legal requirements:

1. A person must be assumed to have capacity unless it is established that they lack capacity in respect of that decision at that time. Assumptions should not be made that someone cannot make a decision for themselves just because they have a particular medical condition or disability

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision

4. An act done or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests

5. Before the act is done or the decision is made regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

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 donee 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 donee 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.

4.5 Completion of a ReSPECT Document and Record-Keeping

Detailed guidance on the completion of the various sections of the ReSPECT document may be found in its accompanying guidance, which is appended to this policy (please refer to appendix 2).

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 current health 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 current health record (see 'amending or cancelling a person's ReSPECT document' section, below). 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.

In addition to (and on behalf of) those with overall clinical responsibility for the care of a person healthcare professionals who are involved in a person's care and who have appropriate

knowledge and skills, may complete or amend a ReSPECT document. Significant amendments should not be made to the document; instead, the document should be cancelled and a new one completed. In these situations, the healthcare professional with overall clinical responsibility, or nominated deputy, should countersign the document.

4.6 If the person remains in the same healthcare setting

A signature of a Consultant should be in place before a person leaves one healthcare setting for another, if the ReSPECT document is to remain valid in the new healthcare setting. Within the healthcare setting where a person is receiving care, the ReSPECT document stored in the person's current health record is the same as the version held by the person. **It is therefore essential that the ReSPECT document is reviewed with appropriate frequency (see section 5.1) according to the person's clinical condition, that it is kept up to date and that its content is shared with all other relevant members of the healthcare team.**

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. In the community, this should include communication with GP and nursing services and may including out-of-hours providers, ambulance services and palliative care services. It may also include sharing via shared electronic patient records, where these are in use. All sharing of a person's ReSPECT information should be documented clearly.

In the event that a person dies, a copy of the most recent ReSPECT document should be present in or added to the person's current health record.

4.7 Validity of a Person's ReSPECT Document

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 setting, in relation to emergency care, including potentially life-sustaining treatments in circumstances where capacity is uncertain the MCA attached to the ReSPECT form must be completed

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.

The ReSPECT process and document are not solely aimed at decisions about limiting treatment; the process 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).

A patient's wishes to have a particular treatment cannot compel it to be offered if it is not available for reasons of resource allocation and a healthcare professional has no legal duty to give a person a treatment that they judge to be futile, or to be clinically inappropriate, including CPR.

5. Review of a Person's ReSPECT Document

The ReSPECT document should be reviewed:

- with appropriate frequency for each individual as part of good clinical care
- if a person's clinical condition changes substantially (deterioration or improvement)
- if a person moves from one healthcare setting to another (including, for example, a change of healthcare team or ward within a hospital)
- if the person or their representative requests it.

Please also refer to the section '**completion of ReSPECT document and record keeping**', above, for further information.

All formal reviews of a person's ReSPECT document should be evidenced by a signature of the reviewer, in the relevant section of the document.

5.1 Review as part of good clinical care

An existing ReSPECT document should be reviewed as part of the usual regular clinical review of any person, in whichever healthcare setting they may be. The frequency of review should take into account the clinical circumstances of the person. For example, if a ReSPECT document is completed in the setting of an acute illness in most cases frequent review of the recorded recommendations will be necessary so that amendment may be considered as the person's condition progresses, whether that constitutes improvement or deterioration and whether or not the progress is what was expected at the time of completion of a ReSPECT document. The healthcare professional with overall clinical responsibility should ensure that a clear plan for review with appropriate frequency is set out in the person's health record and that plan is implemented. If a ReSPECT document is completed for a person who is dying from an advanced and irreversible condition, frequent review may not be needed unless the ReSPECT document contains recommendations for treatment that may not be wanted as the person's condition progresses further. A person who in the community has a ReSPECT document but who has no pressing healthcare needs may not receive routine healthcare reviews.

The healthcare professional with overall clinical responsibility for a person also has responsibility for ensuring that a review is offered or that it has taken place, unless there is good reason for it not to have taken place.

5.2 Review if a Person's Clinical Condition Changes Significantly

If a person's clinical condition or circumstances change substantially, a review of the ReSPECT document as soon as reasonably practicable is essential, to ensure that the recommendations recorded are amended, if necessary, in response to any changes in the person's needs and wishes.

5.3 Review if a Person Moves from one Healthcare Setting to Another

When a person moves from one healthcare setting to another it is important for the healthcare team that has been caring for the person to review the document to check that the recommendations on their ReSPECT document remain appropriate and that the ReSPECT document travels with them to the new setting. However, it is recognised that in some emergency settings (e.g. emergency transfer to hospital from a person's home) such review may not be practicable and it may be necessary to transfer their ReSPECT document with them. In such situations, current decisions remain valid and the review deferred until after their arrival.

It is the responsibility of the clinical team in the receiving care setting to review the ReSPECT document with the person as soon as is reasonably practicable following their arrival, so as to inform the ongoing care of the person. It is the duty of the healthcare professional with overall clinical responsibility for a person to ensure that such review takes place. Formal review of the recommendations on a ReSPECT document should take place whenever a person transfers between healthcare settings as soon as reasonably practicable.

The nature of any review of the ReSPECT document will depend on the particular clinical circumstances of the person. It may not be necessary to review the content of the document with the person or those close to them if there has been no change in the person's clinical condition or their goals of care since the ReSPECT document was completed. This will be a matter of clinical judgement for the healthcare professional with overall clinical responsibility for the person, and other members of the healthcare team. It is important to ensure that patients and those important to them understand that the document applies in the new healthcare setting.

The responsibility for ensuring that review has taken place rests with the healthcare professional with overall clinical responsibility for the person in a given healthcare setting (the actual review may be carried out by a nominated deputy who has the appropriate knowledge and skills to do so). Other members of the wider healthcare team should be involved in the review as appropriate and should be informed of any changes in the recommendations on the person's ReSPECT document. This is as important in the community as it is in hospital and hospice settings.

5.3 Review if the Person or their Representative Requests it

A person who has mental capacity to consider and discuss the relevant decisions may request review of their ReSPECT document at any time. The nature of the review will depend on the person's clinical situation, and on the reason for their request. If a review is requested, this request can be made to any member of the healthcare team in a given healthcare setting but should be passed on to the healthcare professional with overall clinical responsibility for the person who should then ensure that the requested review takes place.

A representative of a person who lacks mental capacity to consider and discuss the relevant decision may also request a review of the ReSPECT document at any time.

If the ReSPECT document's 'review' section is full, the document should be cancelled as above, and a new one completed.

6. <u>Amending or cancelling a person's ReSPECT document</u>

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.

The current document should be marked clearly as being cancelled by writing in black ink 'CANCELLED' between two diagonal lines, together with the signature and name of the person making the cancellation and the date and time of cancellation. The cancelled document should be added to the person's current health record. An entry should be made also in the person's current health record, stating the date and time of cancellation of the document. The healthcare professional with overall clinical responsibility is responsible for ensuring that this has been done.
If the ReSPECT document's 'review' section is full, the document should be cancelled as above, and a new one completed.

Minor amendments can be made to a person's ReSPECT document; if a significant change is needed to any of the recommendations or information contained on a ReSPECT document, it should be cancelled as above, and a new ReSPECT document completed. When any amendment is considered, this should be done with careful adherence to the principles of shared decision-making, good clinical practice, and capacity legislation. Please be aware that the presence of amendments may prevent a decision-maker from using the contents of a ReSPECT document confidently in an emergency setting.

Circumstances when a CPR not recommended decision may not be followed.

There are circumstances in which a CPR decision has been documented in advance, but when the patient suffers cardiorespiratory arrest the attending healthcare professionals assess the situation and make a decision to act contrary to the previously documented decision. Examples of such situations are outlined below.

Occasionally, some people for whom a CPR not recommended decision has been made may develop cardiac or respiratory arrest from a readily reversible cause such as choking, a displaced or blocked tracheal tube, or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the person has made a valid refusal of the intervention in these circumstances. To avoid misunderstandings it may be helpful, whenever possible, to make clear to patients and those close to patients that CPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest and not to an unforeseen event such as a blocked airway.

Temporary Suspension

In addition to readily reversible causes, it may be appropriate to suspend a decision not to attempt CPR temporarily during some procedures, if the procedure itself could precipitate a cardiorespiratory arrest, especially if there is a high probability that prompt treatment of the arrest may be effective. For example, cardiac catheterisation, pacemaker insertion, or surgical operations may trigger cardiorespiratory arrest occasionally. General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment, which may include CPR. Many routine interventions used during anaesthesia (for example tracheal intubation, mechanical ventilation or injection of vasoactive drugs) may also be regarded as resuscitative measures.

Under these circumstances, where a cardiorespiratory arrest and its cause can be treated promptly, survival rates are much higher than those following many other causes of in-hospital cardiac arrest. CPR decisions should be reviewed in advance of the procedure. This should be discussed with the patient, or their representative if they lack capacity, as part of the process of seeking informed consent for the procedure. Some patients may wish a CPR not recommended decision to remain valid despite the risk of a cardiorespiratory arrest from a reversible cause; others will request that the CPR decision is suspended temporarily. The time at which the CPR not recommended decision will be reinstated should also be discussed, agreed in advance and documented. If a patient wants a CPR not recommended decision to remain valid during a procedure or treatment that carries some risk of cardiorespiratory arrest this may increase the mortality risk of the procedure or treatment. As an extreme example, some cardiac surgical procedures require induction of cardiac arrest as a necessary part of the procedure, so treatment could not be completed successfully without reversal of that arrest by defibrillation. If a clinician believes that a procedure or treatment would not be successful or would be unacceptably

hazardous with the CPR not recommended decision still in place, it would be reasonable not to proceed. All discussions and decisions must be documented in the patient's medical notes.

7. ReSPECT across healthcare settings: supporting transferability

For any emergency treatment plan to be effective across healthcare settings it is imperative that:

- It retains validity across healthcare settings and ensures that language used to indicate appropriate treatments is identifiable across care settings
- It is known about widely, and accepted by all health and care provider organisations as valid
- It is instantly recognisable.

A key feature of the ReSPECT document is that it is accepted and valid across all healthcare settings, if completed and reviewed correctly.

7.1 Sharing the ReSPECT Document across Healthcare Settings

The ReSPECT document can only be effective across healthcare settings if the information and recommendations contained in it are shared effectively and without delay with those health and care professionals whose decisions it is intended to inform.

It is essential that the person, and with his / her agreement, their family and / or other carers who have been involved in the process of completing the ReSPECT document, understand its content and are empowered to show it to the healthcare team without delay in any emergency or in any new setting. They (or their representative if they do not have capacity) should also be involved in conversations about sharing the recommendations contained in the document across health and care settings. However, the ultimate responsibility for sharing the contents of the ReSPECT document, even if not the document itself, lies with the healthcare professional with overall clinical responsibility in any given setting. Particular care should be taken if information must be shared urgently, and consideration given to the most appropriate means of sharing of urgent information (e.g. by email or telephone), in line with local procedures and national guidance.

A person's ReSPECT document, including the recommendation about CPR, must be communicated between health and care professionals whenever a person is transferred between healthcare settings, or between different areas or departments in the same healthcare setting, or is admitted to or discharged from a health or care institution. This should not be recorded in another format other than on the ReSPECT form, upon communication with receiving staff / location the form should be checked when verbal handover received.

As the ReSPECT document is a summary of discussions that may have occurred and recommendations that may have been made over a period of time it is important that more detailed information is also shared among all health and care settings involved.

Whilst there are several electronic and paper record systems in existence, it remains essential that a current and 'active' paper copy of the ReSPECT document stays with the person and accompanies them across healthcare settings. This will ensure that the most current version of the document is with the person at all times. If faced with different versions of a ReSPECT document, whether in electronic or in paper format, the decision-maker should proceed on the principle that the paper copy accompanying the person is the active, current, and up to date version. If possible, they should check the date of completion of any duplicate documents and use only the most recently completed valid and applicable version to guide their decision-making in an emergency;

this is likely to be the version that accompanies the person. Any obsolete versions should be cancelled clearly (see above), and a full record of events made in the person's current health record.

7.2 Special considerations for people being discharged from hospital, hospice or other healthcare institution

Prior to discharge the content of the ReSPECT document, including the recommendation about CPR, should be reviewed. Special care should be taken to ensure that the person and those close to them are aware of the decision. Only if it is thought that discussion would be likely to cause them physical or psychological harm should this not be attempted. In circumstances where they have previously indicated that they do not want the information to be shared with those close to them, this must be respected.

Robust reasons for any lack of discussion should be documented clearly in the person's current health record. Under such circumstances, careful consideration should take place about the appropriateness and feasibility of the ReSPECT document accompanying the person themselves, and about whether sharing of important information can take place in another way (for example via a discharge summary). It will be helpful to the health and care teams in the new setting 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.

The ReSPECT document that accompanies the person on discharge should be the most recent, 'active' version. It is recommended that the ReSPECT document is placed in a clear wallet to help protect the document. The document must not be photocopied for clinical use.

8. Training

Decision-making around CPR and other emergency treatment planning requires knowledge, skill and confidence in relation to relevant clinical, legal and ethical principles, effective communication, and good documentation. Although these aspects of clinical care are not specific to the ReSPECT process they are essential for its success.

Clinicians must use effective communication skills in the ReSPECT process, with both the person, and if appropriate family or carers, to enable effective discussions in the decision-making process. Clinicians should have completed Tier 3 in communication skills and the use of the ReSPECT process into existing training for their clinical staff. All healthcare staff should be trained and supported to enable safe and effective use of the ReSPECT document, and participation in this training should be recorded locally and subject to continuous audit. Familiarisation with the ReSPECT process and documentation should also form part of staff mandatory resuscitation training.

In addition to structure face to face teaching sessions the ReSPECT Learning Web-application is available. The app can be downloaded and used on mobile devices as well as desktop computers. The app allows you to learn about the ReSPECT process and how it applies to the health care professional. Within the app it identifies who respect if for, having a conversation about ReSPECT, practicalities about the respect form and how to care for someone with a ReSPECT form including scenarios. Certificates can be printed off and practical tools to enable you to reflect on practice.

9. Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trusts Monitoring Report Template:

Monitoring Requirement :	The Chair for the ReSPECT Group is responsible for audit of issues relating to resuscitation which include decisions relating to ReSPECT. The Group may also contribute towards any investigations or complaints received relating to ReSPECT.
Monitoring Method:	Six month audit of ReSPECT forms within patient's medical notes in clinical areas. Identifying the quality of documentation and completion of the form. Spot checks of ReSPECT forms within patient's medical notes may also be undertaken.
Audit Report Prepared by:	Resuscitation and Clinical Skills Manager
Monitoring Report presented to:	Trust Patient Safety Group
Frequency of Report:	Three Monthly

Any identified deficiencies will be fed back to the individual clinical area and / or clinician with recommended action plans. This will be reported to the Trust ReSPECT Group.

10. References

Court of Appeal Judgement R (David Tracey) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health, 2014

Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision) 2016

MCA Code of Practice [https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice]

ReSPECT, London Policy Version 19. April, 2017

Decisions relating to cardiopulmonary resuscitation Guidance from the British Medical Association, the Resuscitation Council UK and the Royal College of Nursing 3rd edition (1st revision) 2016

https://aace.org.uk/news/respect-recommended-summary-plan-emergency-care-treatment/ ReSPECT Association of Ambulance Chief Executives (published 6 April 2017) April 2018

www.bmj.com/content/356/bmj.j813 April 2018 Resuscitation policy should focus on the patient, not the decision (Published 28 February 2017) April 2018

https://www.bmj.com/content/356/bmj.j813 Emergency care and resuscitation plans, (Published 28 February 2017) April 2018

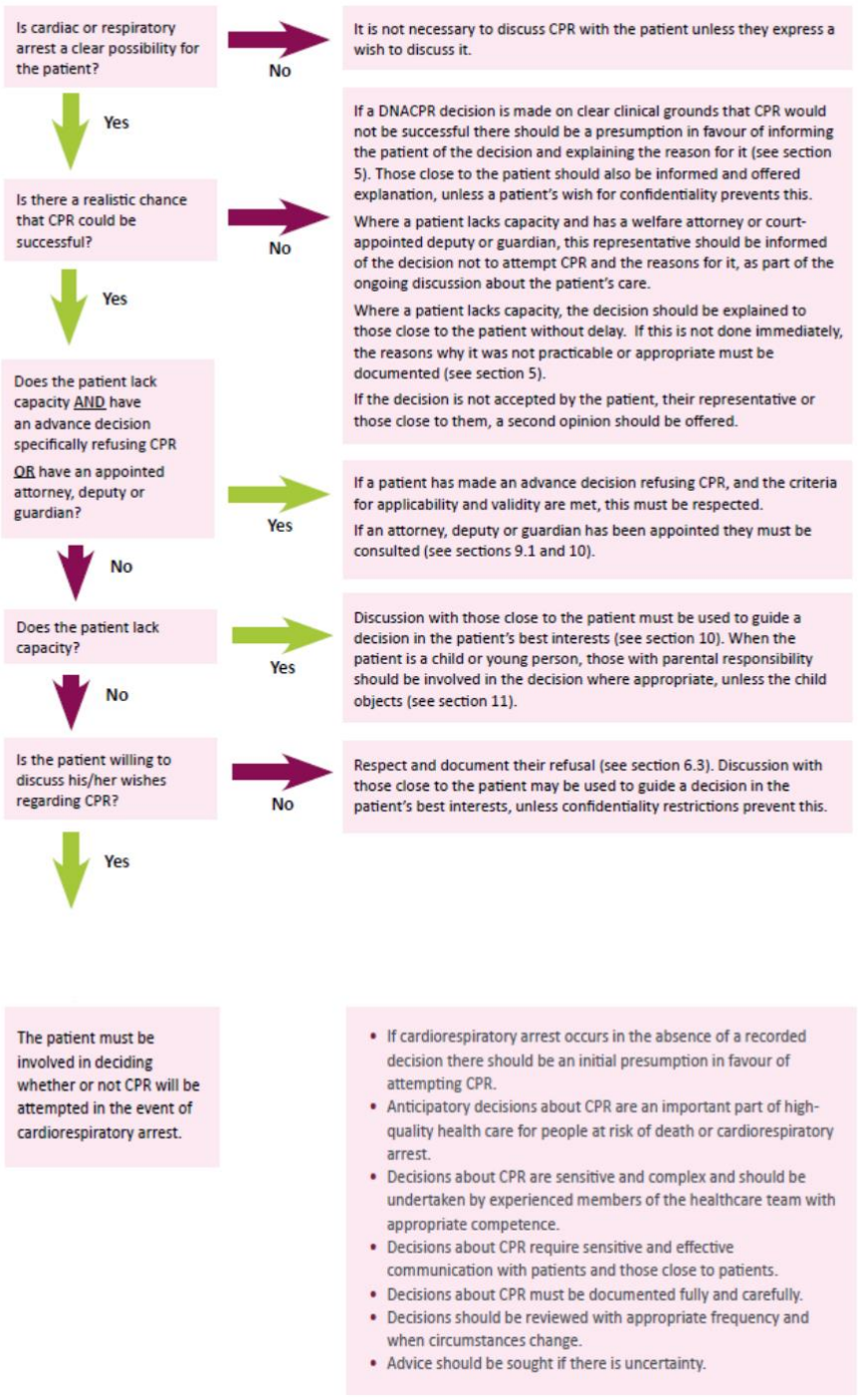
www.resus.org.uk/respect/ April 2018

www.respectprocess.org.uk/ April 2018

https://www.respectprocess.org.uk/learning April 2018

Appendix 1

Decision-making framework



Ref. Decisions Relating to Cardiopulmonary Resuscitation, 3rd edition – 1st revision, Guidance from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing. 2016.

Appendix 2

Resuscitation Council UK

ReSPECT

The ReSPECT process - A guide for clinicians completing the plan

Before you start:

- Remember that completing the plan is only part of the ReSPECT process.
- You can use the sequence of sections on the plan to guide you through the conversation that is an essential part of that process.
- Do **not** complete the plan without maximum possible involvement of the person in the process (or of those best able to speak for them if they do not have capacity for involvement).
- Use the plan to summarise what was discussed and agreed. Document more detailed information in the person's health record.

Section 1: "This plan belongs to"

Complete all details fully and clearly. Those responding to a future emergency must be able to identify the person immediately and confidently.

Section 2: "Shared understanding of my health and current condition"

Discuss, explain and achieve a shared understanding of the person's relevant health conditions and how these may progress or change. Summarise in this section's three boxes:

- relevant conditions and circumstances. Do not record unnecessary detail (e.g. of past medical history, medication). Include communication problems and how to overcome them. Make sure that the person (or anyone speaking for them) knows and agrees with what you record.
- specific detail of any other planning documents and where to find them.
- whether or not they have a legal proxy. If so, put name and contact details in section 8.

Section 3: "What matters to me in decisions about my treatment and care in an emergency"

- Summarise what the person says would matter most to them (values and fears), both in daily life and as an outcome of future emergency treatment. If possible, use their own words. If the person does not have capacity to participate, whenever possible family or other representatives must be involved in establishing what is important to the person.
- Help the person understand how some people want all possible interventions to try to live as long as possible, others want care to focus only on maintaining their comfort and many want a balance between these.
- Explain that this plan is for use only when they cannot express what is important to them about their emergency care and treatment.

Section 4: "Clinical recommendations for emergency care and treatment"

- Record recommendations for a future emergency on interventions that:
- could result in desired outcomes and would be wanted
- are likely to result in a feared outcome and would not be wanted
- have little or no realistic chance of success, so would not work.

Following from clinical understanding and the values and fears agreed in sections 2 and 3, establish an agreed overall goal of care, and sign one of the three boxes:

- **Prioritise extending life:**
  they would receive treatment to control symptoms, and would want potentially life-sustaining treatments, even if they involve some discomfort and/or risk.
- **Balance extending life with comfort and valued outcomes:**
  they would want some potentially life-sustaining treatments in some circumstances.
- **Prioritise comfort:**
  they want care and treatment to control symptoms and maintain their comfort. This does not mean that they should not receive (for example) an antibiotic for an infection. They would not want invasive intervention with a primary purpose of extending life.

Next, record freehand clinical recommendations on **specific interventions** that would or would not be wanted or clinically appropriate, and summarise the reason for these. This may include whether the person would want to be taken to hospital and in what circumstances. Include other relevant recommendations (e.g. whether they should be considered for intensive care, or for 'invasive' ventilation).

Complete this box clearly. Avoid jargon; use wording that will be easily understood by all who may respond to an emergency in any health or care setting.