

TRUST POLICY FOR: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) for Adults

Reference Number POL-CL/2294/2018	Version: First version 1.0	Status Final	Author: Resuscitation & Clinical Skills Manager	
Version / Amendment History	Version	Date	Author	Reason
	1.0	February-April 2018	David Jones	New policy
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: The Consent & Mental Capacity Act Policy and the Trust Policy and Procedures for Resuscitation.				
In consultation with and Date: Community ReSPECT Group, 16 th January 2018. ReSPECT implementation Group, 12 th March 2018. Resuscitation Committee, 29 th March 2018. Documentation Group, 12 th April 2018. Chief Nurse Group, 3 rd May 2018. Browne Jacobson LLP, 8 th May 2108. Clinical Guidelines Group, 9 th May 2018. JLNC, 17 th May 2018. MAC, 17 th May 2018. QRC 24 th May 2018.				
EIRA stage One		Completed Yes		
stage Two		Completed No		
Procedural Documentation Review Group Assurance and Date			Yes, 12 th April 2018	
Approving Body and Date Approved			26 th June 2018, Trust Delivery Group (TDG)	

Date of Issue	27 th June 2018
Review Date and Frequency	June 2021 then every 3 years
Contact for Review	Resuscitation & Clinical Skills Manager
Executive Lead Signature	 Mr Arthur Stephen Interim Executive Medical Director
Approving Executive Signature	 Mr Arthur Stephen Interim Executive Medical Director

Contents

1. Introduction

2. Purpose and Outcomes

Key principles of the ReSPECT document

Definitions used

3. Key Responsibilities/Duties

3.1 Consultants

3.2 Junior Doctors

3.3 Advanced Clinical Practitioners & Clinical Nurse Specialist

3.4 Clinical & Ward Staff

3.5 Resuscitation Committee

4. Who should have a ReSPECT document

4.1 Making clinical decisions in an emergency situation

4.2 Communication and discussion concerning decisions about potentially life-sustaining treatments

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

4.4 ReSPECT for people who lack mental capacity to discuss recommendations and plans for their care and treatment in a future emergency situation

4.5 Completion of a ReSPECT document and record-keeping

4.6 If the person remains in the same healthcare setting

4.7 Validity of a person's ReSPECT document

5. Review of a person's ReSPECT document

5.1 Review as part of good clinical care

5.2 Review if a person's clinical condition changes significantly

5.3 Review if a person moves from one healthcare setting to another

5.4 Review if the person or their representative requests it

6. Amending or cancelling a person's ReSPECT document

7. ReSPECT across healthcare settings: supporting transferability

7.1 Sharing the ReSPECT document across healthcare settings

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

8. Training

9. Monitoring Compliance and Effectiveness

10. References

11. Appendix 1. Decision-making framework

12. Appendix 2. How to complete a ReSPECT form: Quick guide for clinicians

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy

1. Introduction

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 'Do not attempt cardiopulmonary resuscitation' (DNACPR) 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.

Purpose and Outcomes

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 procedures. 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 'How to complete a ReSPECT form: Quick guide for clinicians' (appendix 2).

Scope

This policy applies to all the multidisciplinary health and care teams involved in a person's care in all settings.

This policy is applicable to people aged 18 years and over.

Key principles of the ReSPECT document

The ReSPECT document:

- Is relevant to decisions about **cardiopulmonary resuscitation (CPR), as well as 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).
- 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.**

2. 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 & 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 means (in England & Wales) through which a person aged 18 years and above, who has capacity to do so, may instruct that they should not receive certain treatments in certain circumstances if they lack mental capacity to decide for themselves 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 local policy, for further information.
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.
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.
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.
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 ' <i>emergency treatment plans</i> ', below).
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 & Welfare decisions for themselves at the time it must be made. Please refer to the Mental Capacity Act 2005.
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).
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.
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 person 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 junior doctor, the Consultant must be informed at the earliest opportunity and the sign section 7 of the ReSPECT form.

3.2 Junior Doctors

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

Decisions on ReSPECT can also be made by an appropriately trained Advanced Clinical Practitioner (ACP), trainee ACP or Clinical Nurse Specialist, who has undertaken training and assessment which is delivered by the Trust. All ReSPECT decisions made by an ACP or Clinical Nurse Specialist must be discussed with the patient's own Consultant, Specialist Trainee (ST3) or above or General Practitioner (GP), as part of the decision making process. This consultation must be clearly documented on the ReSPECT document.

3.4 Clinical & 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 Resuscitation Committee

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

4.0 Who should have a ReSPECT document?

The ReSPECT document is intended to be a replacement for the DNACPR form.

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. **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, General Practitioner 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 countersignature 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 include 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.

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.

Please note that 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.

5.0 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 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 has a ReSPECT document but who has no pressing healthcare needs may not receive routine healthcare reviews.

In that situation, it is recommended that the ReSPECT document should be reviewed, or a review offered, at least yearly. The healthcare professional with overall clinical responsibility for a person also has responsibility for ensuring that such review is offered and 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, and to countersign the document. 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

6.0 Amending or cancelling a person's ReSPECT document

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.

Amendments should not be made to a person's ReSPECT document; if a 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.

7.0 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
- 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.

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. If it is thought that discussion would be likely to cause them physical or psychological harm, or if they have indicated that they do not want the information to be shared with those close to them then 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, but may be photocopied for audit or administrative purposes; in this case copies must be crossed through with 2 diagonal lines in black ink and the words "COPY ONLY – NOT FOR CLINICAL USE" should be written clearly between them. A copy should be retained as part of the person's current health record in that setting, and must be crossed through with 2 diagonal lines in black ink and the words "COPY ONLY – NOT FOR CLINICAL USE" should be written clearly between them.

8.0 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.

Healthcare provider organisations should consider how they plan to link training in effective communication 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.

9.0 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 Resuscitation Committee is responsible for audit of issues relating to resuscitation which include decisions relating to ReSPECT. The Committee 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.
Report Prepared by:	Resuscitation & Clinical Skills Manager
Monitoring Report presented to:	The Trust's Resuscitation Committee
Frequency of Report	Six 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's Resuscitation Committee.

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

<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

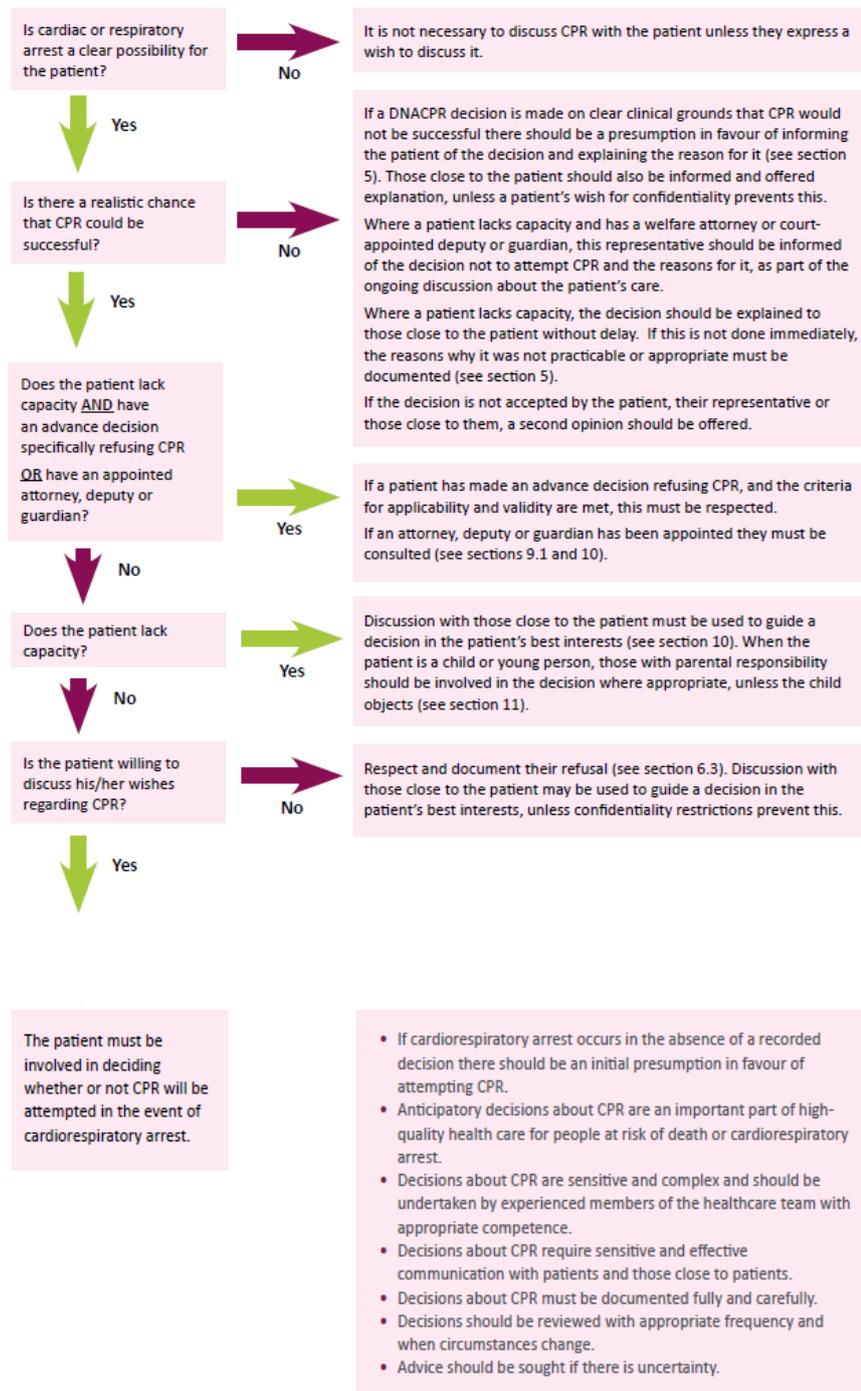
www.resus.org.uk/respect/ April 2018

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.

ReSPECT How to complete a ReSPECT form: Quick guide for clinicians
The numbers relate to the section numbers on the ReSPECT form. Version 1.0

1. Personal details

Insert clearly the person's full name, date of birth and address. Insert the date on which the form is completed. Whenever possible, include their NHS/CHI health and care number.

Preferred name

Ask the person (or if they cannot answer ask their family or other carers) the name by which they would like to be addressed.

2. Summary of relevant information for this plan

Whenever possible complete this in discussion with the person and with reference to available health records. If they do not have capacity to participate in decisions, whenever possible complete this in discussion with their family or other representatives.

A. Insert a brief summary of the background to the recommendations in section 4 (e.g. diagnosis, previous and present condition, prognosis, communication difficulties and how to overcome them);

B. Record specific detail and the location of documents such as advance statements, Advance Decisions to Refuse Treatment, advance care plans, organ donor cards.

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

Ask the person to describe their priorities for their care. The scale can be used to help them to understand how, for some, the emphasis may change from focusing on all possible interventions to try to sustain life to focusing primarily or mainly on care and treatment to control symptoms. The scale can be used to aid discussion only, or a mark can be made on it if they wish. Remember to explain that this plan is for use in an emergency when the person is not able to make decisions about their care and treatment. If they are able to make decisions, they can make choices at the time.

Prioritise sustaining life... Prioritising life-sustaining treatments does not mean that the person would not receive treatment to control symptoms, but they may want to be considered for some life-sustaining treatments that involve a degree of discomfort. There may be clear limits to the types of care and treatment the person would or would not want to be considered for, and on the circumstances in which they would or would not want those.

Prioritise comfort... Prioritising comfort indicates that the person wants primarily those types of care and treatment whose purpose is to control symptoms and provide comfort. This does not mean that the person would not be offered (for example) antibiotic treatment for an infection, especially as that treatment may relieve the symptoms caused by the infection. However the person would not want more invasive types of treatment that involve some discomfort and some risk and whose primary purpose is to sustain life rather than relieve discomfort. The second box is to allow individuals to have recorded the aspect of their life that is most important to them. For some this may be maintaining cognitive function, for others maintaining independence or mobility. Some may want all treatments for some time, but would not want to be on life support for a prolonged period.

4. Clinical recommendations for emergency care and treatment

These are the recommendations to guide decision-making in a future emergency. If the person does not have capacity to participate in deciding these recommendations, their family or other representatives should be involved in discussions whenever possible. Start by signing the goal of care as **either** focusing on life-sustaining treatment **or** focusing on symptom control.

Clinical guidance... Record clear detail of those types of care or treatment that the person would or would not want to be considered for and that would or would not work in their individual situation. Include whether or not the person would want to be taken to hospital and in what circumstances. Include other level-of-care decisions, for example whether they should be considered for intensive care admission, or whether (for example) only non-invasive ventilation would be recommended. It is important to complete this box clearly as it is these recommendations that will be used to guide decision-making in an emergency. Remember that the ReSPECT form is not a substitute for recording a detailed clinical assessment and plan of treatment in the person's health record.

CPR decision... Sign ONE of these boxes ONLY. Remember that there must be a presumption in favour of involvement of the person (and/or their family or other representatives) in the decision-making process unless that would cause the person harm. If CPR would not work and is not being offered, that should be explained in the context of the person's priorities and goals of care.

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan?

Consider and answer this question for all adults. If there is any reason to suspect impaired capacity perform a formal assessment of capacity and document it fully in the person's health records.

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations?

Consider and answer this question for adults and children. When the answer is 'yes' insert details in section 8.

6. Involvement in making this plan

The clinician signing this plan...

You must circle at least one of the statements A, B, C, D. Then record the date (or dates) of conversations about the recommendations and the names and roles of those involved. Make sure that detail of what was discussed and agreed is documented in the health record. On the ReSPECT form record where that further detail has been documented.

If this plan is being completed without involving the patient...

If there has been no shared decision-making with the person themselves (or no involvement of family or other representatives of a person who does not have capacity to be involved) use the red-bordered box to summarise the reasons for this. Make sure that the reasons are detailed fully in the clinical record, together with a clearly defined plan to involve the person or their representatives as soon as this is possible or appropriate.

7. Clinicians' signatures

Clinicians' signatures...

This section **must** be signed (inserting also the date and time of signing) by the professional who completes the ReSPECT form. If that is not the senior responsible clinician, they should be informed of the plan's completion, and at the earliest practicable opportunity they should review and endorse the recommendations by adding their signature (or, if appropriate, consider further discussion and possible revision of the plan). The senior responsible clinician will usually be the person's GP or consultant. In some situations (e.g. nurse-led units) a senior nurse may have this role.

8. Emergency contacts

Use this section to record contact details of people who should be considered for immediate contact in the event of major deterioration, imminent death, or any change in the person's condition that may warrant reconsideration of the previously recorded recommendations.

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

This section should be left blank at the time of initial completion of the plan. Remember to document in the health records whether and when review of the recommendations on this ReSPECT form should be considered. The recommendations on the ReSPECT form do not have a defined expiry date, as the need for review must be considered carefully for each person at each stage of their clinical progress. Review may be prompted by a request from the person or their representative, by a change in the person's condition or by their transfer from one care setting to another. In any of these situations, it is good practice for the responsible clinician to review the content of the ReSPECT form. If they confirm that the recommendations are still correct and appropriate, they should sign and date the review box to indicate that review has occurred. If the recommendations may no longer be correct, another conversation should be had with the patient and, where appropriate, a new ReSPECT form created.