

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

		POLICY
Reference	CPG-TW-ReSPECT	
Approving Body	Advancing Quality Programme (AQP)	
Date Approved	6 <sup>th</sup> October 2021	
For publication to external SFH website	<b>Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:</b>	
	<b>YES</b>	<b>NO</b>
	X	
Issue Date	7 <sup>th</sup> October 2021	
Version	v3.0	
Summary of Changes from Previous Version	<ul style="list-style-type: none"> <li>Incorporated reference to the CQC Document - Protect, respect, connect – decisions about living and dying well during COVID-19 (April 2021)</li> <li>Incorporated minor areas for clarification</li> <li>Updated the list of websites/references</li> <li>Included the current version of the representational copy of the ReSPECT Form and ReSPECT Mental Capacity Assessment Form</li> </ul>	
Supersedes	v2.0, Issued 20 <sup>th</sup> April 2020 to Review Date October 2021 (ext <sup>3</sup> )	
Document Category	<ul style="list-style-type: none"> <li>Clinical</li> </ul>	
Consultation Undertaken	<ul style="list-style-type: none"> <li>General Palliative and End of Life Care Committee</li> <li>Resuscitation Advisory Group</li> </ul>	
Date of Completion of Equality Impact Assessment	5 <sup>th</sup> August 2021	
Date of Environmental Impact Assessment (if applicable)	5 <sup>th</sup> August 2021	
Legal and/or Accreditation Implications	Statutory law and related legislation.	
Target Audience	Clinical Staff and the patients they care for. This policy does not relate to visitors unless there are existing and known legally valid and applicable existing decisions	
Review Date	October 2024	
Sponsor (Position)	Medical Director	
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Lead Division/ Directorate	Corporate	
Lead Specialty/ Service/ Department	Corporate / End of Life Care	
Position of Person able to provide Further Guidance/Information	Lead Nurse for End of Life	
<b>Associated Documents/ Information</b>		<b>Date Associated Documents/ Information was reviewed</b>
Nationally approved form for ReSPECT Decisions		Available to order from the Trust's forms management system (Ref FKIN030304)
Template control		June 2020

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## 1.0 INTRODUCTION

This policy details the standards, considerations and procedures within Sherwood Forest Hospitals, relating to a broad range of treatment and care decisions but with a particular focus on those decisions relating to life sustaining treatment including but not exclusively cardiopulmonary resuscitation decisions to ensure the resuscitation status and the treatment plan of the patient is determined in accordance with current statutory law and related legislation, using national quality and professional standards and approved guidance.

Adherence to this process supports the provision of a holistic approach which involves individual assessment, assists patients to make informed decisions and voice their preferences, to maintain the patient's dignity, and respect of their free will if they do not wish to be resuscitated or refuse other life sustaining and or important [to either the patient or the Trust] treatment. It does not preclude them from the offer of basic care and support at any stage.

**It is important to make very clear that with the development of a new national and voluntary Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) that the previous policy which was specific to cardiopulmonary resuscitation (CPR) has now changed.**

Associated terminology commonly used nationally is Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) or previously used in this Trust and its policy as Allow a Natural Death (AND) and has been superseded by this ReSPECT process and supporting policy. Existing valid and applicable DNACPR orders or equivalent now need to be considered in the context of a ReSPECT process and plan and where possible transferred to this new format.

This policy should be read and aligned appropriately with the current [CPR Policy](#) for Adult, Maternity & Paediatric Patient and other policies as summarized.

This policy is issued and maintained by the Executive Director sponsor on behalf of the Trust, at the "issue" number stated on the front sheet, which supersedes and replaces all previous versions.

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, despite recent advances in healthcare life cannot always be extended, 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 where this is likely to be successful.

However, for many people, CPR will have minimal or no chance of success, and provide no benefit and cause harm, 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 (Advance Decisions to Refuse Treatments or ADRTs), or the views of proxy decision-makers who have been appointed to act on the persons behalf especially those with Lasting Power of Attorney with specific donated powers for healthcare and treatment decisions.

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.

## 2.0 POLICY STATEMENT

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, 2020) and a growing demand for a national form for recording anticipatory recommendations about CPR and for a treatment-escalation-plan-style document.

Standards have been reinforced by the CQC Report updated April 2021 "Protect, respect, connect – decisions about living and dying well during COVID-19"

The findings show that there needs to be a focus on three key areas:

1. Information, training and support
2. A consistent national approach to advance care planning
3. Improved oversight and assurance

The report calls for an individualised approach with active involvement of the person / those close to them; clear documentation of the process and outcome of the discussions; leadership to ensure decisions are valid. These processes are reflected in the current policy and national ReSPECT process.

<https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19>

ReSPECT is a process and its aims 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).

## Scope

This clinical document applies to:

### Staff group(s)

- This policy applies to all clinical staff that are employed by or on behalf of the Trust who have a duty to provide clinical care for patients.

### Clinical area(s)

- This policy applies Trust-wide to all sites and all clinical areas where adult patients are cared for and treated.

## Patient group(s)

- This policy applies to all patients noting the legal differences for those under the age of 18 years. This ReSPECT tool can be used in those younger than 18 and will support paediatric personal resuscitation planning (see next section)

## Exclusions and Age related variations

- Separate Paediatric Personal Resuscitation Plan Documentation and the associated clinical process must be used for those patients under the age of 18. These will be reflected in the ReSPECT documentation.

## 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 to refuse, in advance, any treatment, and for those aged 18 years and above 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 [‘How to complete a ReSPECT form: Quick guide for clinicians’](#)

### 3.0 DEFINITIONS/ ABBREVIATIONS

<b>Advance care planning (ACP)</b>	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.
<b>Advance Decision to Refuse Treatment (ADRT)</b>	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 and applicable, an ADRT refusing life sustain treatment must exist in writing, be signed and witnessed and meet specific criteria. Please refer to the Mental Capacity Act 2005, and local policy, for further information.
<b>Advance statement</b>	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.
<b>Best interests</b>	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.
<b>Cardiorespiratory arrest</b>	The cessation of cardiac output and spontaneous breathing, inevitably leading to death.
<b>Consent</b>	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.
<b>Cardiopulmonary resuscitation (CPR)</b>	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.

<p><b>Health records</b></p>	<p>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.</p>
<p><b>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision</b></p>	<p>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.</p>
<p><b>Emergency treatment decisions</b></p>	<p>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).</p>
<p><b>Lasting Power of Attorney (LPA)</b></p>	<p>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 &amp; Welfare decisions for themselves at the time it must be made. Please refer to the Mental Capacity Act 2005.</p>
<p><b>Potentially life-sustaining treatment</b></p>	<p>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).</p>
<p><b>Mental Capacity</b></p>	<p>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.</p>
<p><b>Provider organisation / healthcare provider organisation</b></p>	<p>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.</p>

<p><b>Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document</b></p>	<p>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 the process it was completed. The document records recommendations about potentially life-sustaining treatments for a person, including a recommendation about CPR.</p>
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## 4.0 ROLES AND RESPONSIBILITIES

### When embarking upon this process, the decision maker must:

- Have accessed relevant training and education to authorise them to perform this role
- Have considered and accessed the policy to clarify any concerns where relevant and or consulted a more senior or experienced clinician.
- Comply with any legally binding advance refusal of treatment including cardiopulmonary resuscitation or other life sustaining treatment, as part of an existing, valid and applicable advance decision to refuse treatment (ADRT)
- Respect the wishes of the patient wherever possible
- Ensure the statutory process of a best interests assessment is completed where the patient lacks capacity to be involved in the decision making process and there is no pre-existing legally binding ADRT or specific LPA with these powers
- Provide benefits that are not outweighed by burden
- Meet the requirements of this clinical policy, the standards and behaviours of an employee of this Trust and of their profession

**Where possible the roles and responsibilities of clinical staff include proactively promoting and agreeing Advance Care Plans wherever possible.**

**Any existing ReSPECT document must be considered at every new episode of treatment and care especially at the first consultant review, after transfer to a new location / team, or when a patient’s clinical status changes. This is to avoid staff having to make decisions in a crisis situation, when there may be insufficient time to gather and consider all of the relevant information relating to the patient’s wishes and clinical condition. Sufficient time and opportunity must be made to do this. Where this cannot be done initially (for good clinical reason) *and* can be delayed this task must be reassigned to another time and competent practitioner.**

### 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 sign section 7 of the ReSPECT form. Most consultants are doctors but this role definition can apply to other non-medical consultants. These staff can also make such decisions with appropriate competency.

### Junior Doctors

In some situations where a discussion surrounding ReSPECT takes place with a junior doctor with a patient, relative, carer or Independent Mental Capacity Advocate (IMCA), the doctor must refer to a more senior colleague who must be of at least ST3 (registrar) or equivalent, who

would commence the decision making process and complete a ReSPECT document. Any such decision made by a junior doctor must be reviewed by the Consultant responsible for that patient at the first available opportunity.

### **Advanced Clinical Practitioners & Clinical Nurse Specialist**

Decisions on ReSPECT can also be made by an Advanced Clinical Practitioner (ACP) or Clinical Nurse Specialist, who has undertaken training and assessment which is delivered by the Trust or has another approved training competency. 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.

### **Clinical & Ward Staff**

Decisions included in a ReSPECT document must be understood by a broad number of clinical and ward staff. Reviews can be prompted by staff for a number of reasons. It should be considered normal that every ward or board round, at transfers of care or discharge that ReSPECT decisions are reviewed. If there are any subsequent changes in the decision the patient should be consulted about the decision and the reason for any change. Any changes must be documented and shared appropriately with these staff groups.

### **Resuscitation and Deteriorating Patient Groups**

It is these groups responsibility to continue to develop and monitor the compliance with the policy and ReSPECT document and report to The Trust's Patient Safety Quality Group.

## **5.0 APPROVAL**

Following consultation, this policy has been approved by the Trust's Advancing Quality Programme Group.

## **6.0 DOCUMENT REQUIREMENTS**

### **6.1 Who should have a ReSPECT document?**

***The ReSPECT document is intended to be a replacement for the DNACPR form and also extends to a wider set of clinical decisions that can be either in part of an emergency response or a planned system of proactive treatment and care.***

The ReSPECT document captures decisions for both adults and children. In this Trust there is a separate policy for those patients younger than 18 years of age. This ReSPECT process does not replace or change the legal process to make decisions especially where the decision will have a significant impact on the patient and those close to them. A representational copy of the form can be seen at [Appendix A](#).

The ReSPECT document should primarily address emergency care and treatment and will often include potentially life-sustaining treatment, including CPR. It is possible though that other non-emergency or non-life threatening treatment and care decisions could be recorded. Such people may already have an existing illness, such as advanced organ failure, advanced frailty or advanced cancer. As a minimum, it **must** be considered for any person that is at foreseeable risk of cardiorespiratory arrest, as is currently recommended for anticipatory decisions about

CPR. This process can naturally extend into the formulation of a broader advance care plan which might offer more instruction or support after discharge.

Advance care planning can happen at any stage and the person's wishes or statements may lead to a ReSPECT document being considered, discussed and completed even in the absence of advanced illness. This type of planning helps the "decision maker" especially when mental capacity is lost for this decision. This process is subject to the statutory requirements of the Mental Capacity Act and its Code of Practice.

## **6.2 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, the gold standard being the consultant or GP in charge at that time. Decisions can be made by other registered practitioners with the appropriate knowledge and skill to make these decisions. The non-consultant practitioner must take every practical opportunity to seek and gain the endorsement of a consultant in charge at the earliest stage.

**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 must be a presumption in favour of providing treatment that is potentially life-sustaining until any doubt has been resolved. 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).

## **6.3 Communication and discussion concerning decisions about potentially life-sustaining treatments**

There must be a specific reason not to discuss these issues with the patient and those close to them. This applies even if CPR is thought to have little or no chance of a successful outcome. Patients have statutory rights set out in law especially those with particular vulnerability such as those who lack capacity and have no representative / unbefriended require independent mental capacity advocacy.

The legal threshold for not engaging the patient or their representative in such a discussion is set high and in simple terms there has to be a clear anticipation that the patients involvement in the discussion will lead to physical or psychological harm. It is acceptable that discussions can cause mild to moderate degree of distress. Patients must be offered support and advice to reduce the impact of such discussions.

A healthcare professional has no legal duty to give a person a treatment that they judge to have no reasonable\* chance of success and 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.

(\* What a patient or those close to them perceives as reasonable maybe different compared to the healthcare professional. This concept of what is deemed reasonable has developed in case law around consent. For this policy Reasonable should be better considered as a decision taken within a clinic-ethical framework and a best interests checklist might help set this out.)

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 neither the person (who is deemed to lack capacity) 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.** "Emergency Decisions" must be taken in these circumstances where there is anticipation of an imminent need to perform life sustaining treatment.

Any transfer or discharge from hospital or other care providers requires key information to be shared. This applies to these decisions captured on the ReSPECT document. Care should be taken to identify who and how to share this information safely and appropriately.

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

There are specific statutory and common law requirements for decision making for treatments. In broad terms 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.

Only adults (those of 18 years or older) are able to make legally binding advance decisions to refuse life sustaining treatment (MCA 2005) such as cardiopulmonary resuscitation.

There are different statutory rights affecting those subject to the Mental Health Act.

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.

## 6.5 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.

A new second and supplementary form (see [Appendix B](#)) is now supplied in addition to the national form. The purpose of this form is twofold:

- To act as a process to identify and where necessary, assess the mental capacity of the person to be involved in treatment and care decisions and record this in an approved format
- To act as a physical / paper record of any summary decisions to be retained in the case notes after discharge

Completing this second form should be at the time of any capacity assessment and before discharge. This form is then stored in the front section of the case notes after the patient is discharged.

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 least 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.**

## 6.6 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 quick guide: [How to complete a ReSPECT form](#).

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. The status of the

ReSPECT process and the requirement for resuscitation or not should be recorded electronically (and maintained) on Nerve Centre (the electronic patient record).

### 6.7 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) 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.

### 6.8 Validity and Applicability 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 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.

## 6.9 Review of a person's ReSPECT document

The ReSPECT document must 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
- Before discharge from Hospital.

This review is not a passive review to just confirm the existence of a decision but should be active confirmation of the validity of the decision and ensure it meets the standards set out by this policy and the law. This may include a further senior review.

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.**

### 6.9.1 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.

### **6.9.2 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.

### **6.9.3 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.

Reviews can be prompted by any member of the team but the professional or their deputy re-confirming or endorsing or changing the decision must have the appropriate knowledge and skills to do so. As part of a review other members of the wider healthcare team should be consulted where appropriate, and should be informed of any changes in the recommendations on the person's ReSPECT document. This process is important in any transition and into any care setting including discharge to the patient's home address.

#### 6.9.4 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**

#### 6.9.5 Escalation of Clinical, Patient/ Family Concerns about ReSPECT recommendations

Staff should consider how and who to escalate any clinical or patient / family concerns if they arise. The speed of escalation and the expected response will be informed of the nature of the concern and clinical situation.

The clinical situation is not in keeping with the ReSPECT recommendations where:

- the ReSPECT status places overly restrictive or limiting recommendations to the given situation of the patient such as DNACPR or not offering similar life sustaining treatment where the patient seems well and can or is recovering
- the ReSPECT status recommends treatment and care plans that may be ineffective and inappropriate such as CPR or similar life sustaining treatment where the patient is showing signs of irreversible deterioration and imminent death

The expectations and plans of the staff and patient / their representatives cannot be agreed after:

- attempts by the team to initially resolve the disagreement
- the provision of independent or second opinion to inform the discussion and decision making process
- the possible involvement of informal or formal independent advocacy
- a formal best interest decision making meeting( where the aforementioned action must be considered)
- discharge with the support of the Patient Experience Team where disagreement is presented as a concern or complaint

The escalation process is:

- to be led at a local team level with the active involvement of the senior responsible clinician
- timely and in keeping with the clinical triggers and responses
- supported by the appropriate clinical specialist teams where necessary (e.g. ICCU for HDU / ICCU support)

- reflects the Trust wide escalation process and involvement of senior clinical and management staff
- identifies expert help at an early stage where the existing approaches has not be able to reach agreement

## 6.10 Documentation and Communication

- All discussions between medical personnel, the patient and their relatives/carers must be documented clearly in the patient's medical records and ReSPECT form, identifying the following key information as required by the ReSPECT form:
- *All patients where a ReSPECT form has been completed must have this attached prominently at the front of their medical case notes.* The forms can be found in all appropriate clinical areas and are available to order on the forms management system.
- The Clinician initiating the *ReSPECT form* is initially responsible for promptly communicating this action to all other relevant health professionals. These will include:
  - The nurse in charge when the decision is made.
  - Fellow Clinicians involved in the patients care, with importance stressed during team handover periods.

The clinicians responsible for the ongoing care and discharge must communicate this to the patient's General Practitioner (particularly regarding patients receiving terminal care in the community) or to a receiving team during transfer providing them with the most up to date version as a paper or electronic copy.

- Nursing staff asked by relatives about the CPR status of a patient should refer the relative to the patient's medical team. Such information should not be divulged over the telephone by nursing staff.
  - The aforementioned staff will be responsible for ensuring the information is cascaded promptly to relevant colleagues and clearly documented in associated patient documentation.
  - The status of the ReSPECT process and the requirement for resuscitation or not should be recorded electronically (and maintained) on Nerve Centre (the electronic patient record)

## 6.11 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.

Any change in the status of a ReSPECT decision must be reflected in the Nerve Centre status as soon as practical.

## **6.12 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.

## **6.13 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.

#### **6.14 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 latest version document must be photocopied at discharge and be retained in the front section of the notes, the original copy accompanies the patient.

For patients where the ReSPECT plan is part of their End of Life Care (with usually 12 months or less prognosis) staff must consider working with specialist teams or clinical nurse specialists to register this ReSPECT plan as part of the local Electronic Palliative Care Coordination System (EPaCCS). Where access to EPaCCS is not available the ReSPECT plan can be shared through the discharge information to the GP or other community or health / social care providers. For patients where is likely soon after discharge (such as those on the Fast Track Continuing Health Care pathway) the Integrated Discharge and Assessment Team must ensure all relevant information including ReSPECT plans are shared.

## 6.15 Patients benefiting from life sustaining devices / equipment

In general all devices or equipment that sustains life must be reviewed in the context of care of a dying patient. This might vary with the device and the trajectory of the deterioration. These might include cardiac devices such as pacemakers with ICD functions (see below) ventilator devices, pumps to deliver treatment for diabetes or other conditions such as Parkinson's Disease.

### Implantable Cardioverter Defibrillator (ICD)

- It is the responsibility of the Clinician in charge of the patient's care to address the potential need to deactivate the **defibrillator** function of an ICD.
- In accordance with good practice, consultants should consult with patients and their carers where appropriate to incorporate the ICD deactivation decision process in the patient's plan of care. This should be done prior to the very end stage of life to avoid unnecessary patient mental and physical distress.
- The pacemaker function should remain active, even in terminally ill patients.
- Patients deemed to be approaching end-stage heart failure, or other illness, are at risk of developing complex arrhythmias which may trigger the firing of the ICD. In these circumstances, it would be inappropriate to maintain the ICD in active mode, resulting in patient distress.
- Deactivation can be accessed via Cardiorespiratory Department staff Monday-Friday 0900-1700 hours.
- Out of hours magnets necessary to perform this task can be found on ward 23, the Emergency Department, & Minor Injuries Unit at Newark hospital.
- For those patients who lack capacity, Clinicians must adhere to the guidelines outlined in the 2005 Mental Capacity Act during the decision-making process.

## 6.16 Frequently Given Answers (during engagement and training sessions)

- **Start Date** for ReSPECT implementation 1<sup>st</sup> April 2019
- **ReSPECT builds on existing clinical requirements and competencies** that are a current required standard in the Trust.
- **ReSPECT is a national process** being implemented across Nottinghamshire
- **ReSPECT will be recognised by all providers** including the ambulance services and in any environment
- **ReSPECT is a must do** for this Trust
- **Patient Safety is paramount** and any uncertainty of ReSPECT plans must be resolved or escalated quickly to the senior responsible clinician
- **AND (Allow a Natural Death) Forms will no longer be available and new forms should not be issued** after April 1<sup>st</sup> 2019 as the ReSPECT form will have superseded this
- **Old ANDs or DNA CPR forms will be followed and where possible updated to ReSPECT in the transition period. Very few old forms should still be in existence and if they are they will require review.**
- **ReSPECT is a proactive and dynamic process** and needs to develop during the admission of a patient; this might mean agreeing resuscitation status earlier than other treatment or care decisions
- **Mortality data requires earlier consideration of ReSPECT** in assessment and admission areas

- **Appropriate early involvement and communication with those close to the patient is paramount** even out of hours where the patient's status might have deteriorated
- **Mental Capacity and Decision Making processes must be recorded** according to Trust policy
- **Supporting Information** must be recorded in the clinical documentation as ReSPECT is the summary
- **ReSPECT status and any plans should be reviewed frequently** although this does not mean asking the patient every time unless there is a significant change.
- **Nerve Centre must be kept up to date with the separate tags for the presence of a ReSPECT plan and Do Not Attempt CPR status.**
- **Communication and handover in clinical areas where there is no Nerve Centre-** there is a clinical responsibility for staff to use other forms of communication to identify the presence of a ReSPECT plan or Do Not Attempt CPR status.
- **ReSPECT status must be communicated to the GP** through electronic discharge
- **Other clinical documentation systems or templates must be updated** (by the template or policy owners) to reflect this policy and system of care. Interim changes may be deemed necessary provided it is clear what the management plan is.

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

<b>Minimum Requirement to be Monitored</b>  (WHAT – element of compliance or effectiveness within the document will be monitored)	<b>Responsible Individual</b>  (WHO – is going to monitor this element)	<b>Process for Monitoring e.g. Audit</b>  (HOW – will this element be monitored (method used))	<b>Frequency of Monitoring</b>  (WHEN – will this element be monitored (frequency/ how often))	<b>Responsible Individual or Committee/ Group for Review of Results</b>  (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
To assess the proportion of in-patients with active ReSPECT Plans that meet the quality standard set out in this policy and documentation	Resuscitation Team / EOLC Team/ Care team	Audit (quality)	Quarterly	Reporting to Advancing Quality Programme Group
To assess the proportion of in-patients with active ReSPECT Plans that meet the quality standard set out in this policy and documentation	EOLC Team/ Ward Auditors	Audit (monthly)	Monthly	Reporting to the ReSPECT Task and Finish Group

## 8.0 TRAINING AND IMPLEMENTATION

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.

Throughout 2018-19 there has been a process of engagement and training for employed staff of this Trust, in effect those individuals or teams which will follow or make such decisions. Existing mandatory training such as resuscitation (accredited Resuscitation Council courses) or Mental Capacity Act training will in part address the learning needs of individuals.

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 induction and mandatory resuscitation training.

In addition to 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 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix C](#)
- This document is not subject to an Environmental Impact Assessment, see completed form at [Appendix D](#)

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

[Protect, respect, connect – decisions about living and dying well during COVID-19 | Care Quality Commission \(cqc.org.uk\) \(April 2021\)](#)

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

[www.resus.org.uk/respect/](http://www.resus.org.uk/respect/) April 2018

**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

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

[www.respectprocess.org.uk/](http://www.respectprocess.org.uk/) (2014 to 2021)

- [Decisions relating to CPR \(cardiopulmonary resuscitation\) \(bma.org.uk\)](http://bma.org.uk) (2020)
- [The Mental Capacity Act](#) (2005)
- [General Medical Council \(2010\). Treatment and care towards the end of life: good practice in decision making.](#)

#### Related SFHFT Documents:

- [The CPR Policy for Adult, Maternity & Paediatric Patients](#)
- [End of Life Care Guidelines](#)
- [Mental Capacity Act \(MCA\) Policy](#)
- [Your Guide to Decisions Relating to Cardiopulmonary Resuscitation \(CPR\) July 2016](#) Public Information leaflet accessible via the Resuscitation Department intranet site.

## 11.0 KEYWORDS

DNACPR; do not attempt cardiopulmonary resuscitation; AND; allow natural death; ADRT; advance decision to refuse treatment; decisions; life sustaining treatment; emergency; process; limiting; ACP; advance care planning

## 12.0 APPENDICES

- [Appendix A](#) – ReSPECT Form (**representational copy**) (updated version included)
- [Appendix B](#) – Additional Mental Capacity Act Assessment Form (**representational copy**) (updated version included)
- [Appendix C](#) – Equality Impact Assessment
- [Appendix D](#) – Environment Impact Assessment

APPENDIX A – ReSPECT Form (Representational Copy)

**ReSPECT** Recommended Summary Plan for Emergency Care and Treatment

**1. This plan belongs to:**

Preferred name: \_\_\_\_\_

Date completed: \_\_\_\_\_

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

NHS/CHI/Health and care number: \_\_\_\_\_

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

**2. Shared understanding of my health and current condition**

Summary of relevant information for this plan including diagnoses and relevant personal circumstances: \_\_\_\_\_

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer): \_\_\_\_\_

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8  Yes  No

**3. What matters to me in decisions about my treatment and care in an emergency**

Living as long as possible matters most to me Quality of life and comfort matters most to me

What I most value: \_\_\_\_\_ What I most fear / wish to avoid: \_\_\_\_\_

**4. Clinical recommendations for emergency care and treatment**

Prioritise extending life  Balance extending life with comfort and valued outcomes  Prioritise comfort

clinician signature \_\_\_\_\_ clinician signature \_\_\_\_\_ clinician signature \_\_\_\_\_

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance: \_\_\_\_\_

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

clinician signature \_\_\_\_\_ clinician signature \_\_\_\_\_ clinician signature \_\_\_\_\_

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**5. Capacity for involvement in making this plan**

Does the person have capacity to participate in making recommendations on this plan?  Yes  No

If no, in what way does this person lack capacity? \_\_\_\_\_

Document the full capacity assessment in the clinical record. If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

**6. Involvement in making this plan**

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

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

B This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

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

1 They have sufficient maturity and understanding to participate in making this plan

2 They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.

3 Those holding parental responsibility have been fully involved in discussing and making this plan.

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

**7. Clinicians' signatures**

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

**8. Emergency contacts and those involved in discussing this plan**

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: <input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional

**9. Form reviewed (e.g. for change of care setting) and remains relevant**

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: Name: \_\_\_\_\_ DoB: \_\_\_\_\_ ID number: \_\_\_\_\_

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**APPENDIX C – EQUALITY IMPACT ASSESSMENT FORM (EQIA)**

<b>New Policy: ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy</b>			
<b>Existing Policy: As above</b>			
<b>Date of Assessment: 5<sup>th</sup> August 2021</b>			
<b>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</b>			
<b>Protected Characteristic</b>	<b>a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?</b>	<b>b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?</b>	<b>c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality</b>
<b>The area of policy or its implementation being assessed:</b>			
<b>Race and Ethnicity</b>	N	Current Trust clinical policies address this.	There are no new or existing barriers to this new policy. Engagement and Training mitigates any staff or organisational barriers to change.
<b>Gender</b>	N		
<b>Age</b>	N		
<b>Religion</b>	N		
<b>Disability</b>	N		
<b>Sexuality</b>	N		
<b>Pregnancy and Maternity</b>	N		
<b>Gender Reassignment</b>	N		
<b>Marriage and Civil Partnership</b>	N		

<b>Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)</b>	N		
<b>What consultation with protected characteristic groups including patient groups have you carried out?</b> <ul style="list-style-type: none"> <li>There has been a national process of formal consultation. There has been a local engagement process which continues with forums including Cancer Patient and Carer Group, Council of Governors and clinical specialists representing those patients vulnerability and protected characteristics</li> </ul>			
<b>What data or information did you use in support of this EqIA?</b> <ul style="list-style-type: none"> <li>There has been a national process of formal consultation that took specific data and representative groups into account</li> </ul>			
<b>As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?</b> <ul style="list-style-type: none"> <li>The policy owner is trained in Human Rights, this policy seeks to positively reinforce these rights of patients and carers as well as those delivering treatment and care.</li> </ul>			
<b>Level of impact</b>  From the information provided above and following EQIA guidance document Guidance on how to complete an EIA ( <a href="#">click here</a> ), please indicate the perceived level of impact:  Low Level of Impact. Similar policies have been successfully implemented in other Trusts nationally.			
<b>Name of Responsible Person undertaking this assessment: Dr Ben Lobo, Trust Medical Lead, End of Life Care</b>			
<b>Signature: Dr Ben Lobo</b>			
<b>Date: 5<sup>th</sup> August 2021</b>			

## **APPENDIX D – ENVIRONMENTAL IMPACT ASSESSMENT FORM**

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

<b>Area of impact</b>	<b>Environmental Risk/Impacts to consider</b>	<b>Yes/No</b>	<b>Action Taken (where necessary)</b>
<b>Waste and materials</b>	<ul style="list-style-type: none"> <li>• Is the policy encouraging using more materials/supplies?</li> <li>• Is the policy likely to increase the waste produced?</li> <li>• Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?</li> </ul>	No	
<b>Soil/Land</b>	<ul style="list-style-type: none"> <li>• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals)</li> <li>• Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)</li> </ul>	No	
<b>Water</b>	<ul style="list-style-type: none"> <li>• Is the policy likely to result in an increase of water usage? (estimate quantities)</li> <li>• Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water)</li> <li>• Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)</li> </ul>	No	
<b>Air</b>	<ul style="list-style-type: none"> <li>• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.)</li> <li>• Does the policy fail to include a procedure to mitigate the effects?</li> <li>• Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?</li> </ul>	No	
<b>Energy</b>	<ul style="list-style-type: none"> <li>• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)</li> </ul>	No	
<b>Nuisances</b>	<ul style="list-style-type: none"> <li>• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?</li> </ul>	No	