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

POLICY

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Approving Body	General Palliative and End-of-Life Care Committee
Date Approved	30th October 2024
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**

YES	**NO**	**N/A**
X		

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Sponsor (Position)	Medical Director
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Lead Division/ Directorate	Clinical Support, Therapies and Outpatients
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Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
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CONTENTS

1.0 INTRODUCTION

This policy outlines the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process and its use within Sherwood Forest Hospitals NHS Foundation Trust (SFHFT). It is designed to ensure that decisions relating to a person's clinical care and treatment in a future emergency, including cardiopulmonary resuscitation (CPR) decisions, are made with the person (or representative(s) of a person who lacks capacity) and those important to them, and are realistic and appropriate to the situation. It corresponds directly with the Nottingham and Nottinghamshire Integrated Care System ReSPECT Standard Operating Process, to ensure coordinated care between care settings.

This policy should be read and aligned appropriately with the current SFHFT Resuscitation Policy for Adult, Maternity and Paediatric Patients (showcontent.aspx) and other policies, as summarised.

Implementation of this policy at SFHFT is supported by the Trust document "ReSPECT - Living and Dying Well, Summary of ReSPECT Policy" (showcontent.aspx).

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.

2.0 POLICY STATEMENT

The ReSPECT process was developed by a UK-wide group, facilitated by the Resuscitation Council (UK) and the Royal College of Nursing. Its development was initiated following a systematic review of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision-making and in light of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'Time to Intervene' report (2011), which discussed 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 (Winspear v City Hospitals Sunderland NHS Foundation Trust), the national guidance 'Decisions relating to Cardiopulmonary Resuscitation' (BMA, RC (UK), RCN, 2016) and a growing demand for a nationally universal form for recording anticipatory recommendations about resuscitation and for a treatment-escalation-plan-style document.

ReSPECT is a **process**, which creates a summary of personalised recommendations (including a resuscitation decision), for a person's clinical care, in a future emergency in which they do not have capacity to make or express choices (this may include death or cardiac arrest, but is not limited to just these events) through conversations with the patient (or representative(s) of a person who lacks capacity) and one or more of the health professionals involved in their care.

ReSPECT conversations follow the ReSPECT process by:

1. Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future
2. Identifying what is important to the patient in relation to goals of care in the event of a future emergency

3. Recording an agreed focus of care (either more towards life-sustaining treatments or more towards prioritising comfort over efforts to sustain life)
4. Making and recording shared recommendations about specific types of care and realistic treatment that should/shouldn't be given, and sensitively explaining recommendations about treatments that would clearly not work in their situation
5. Making and recording a shared recommendation about whether or not CPR is recommended.

The ReSPECT process and documentation can be initiated and completed in any healthcare setting (including acute, hospice, care home, primary care or community settings); it can be shared between care settings, and is valid across all of them, to ensure the best care for the person wherever they may be.

The ReSPECT process is not solely aimed at decisions about limiting treatment; it is also 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 of Policy

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 set out the principles and support the timely, safe and effective implementation of the ReSPECT process across all healthcare settings
- To ensure that any decisions relating to a person's care and treatment, including CPR decisions are made with the person (or representative(s) of a person who lacks capacity) and those important to them, and to ensure that such decisions are appropriate to

circumstance, realistic and include any limitations; with reference to current national guidelines and compliance with The Mental Capacity Act 2005

- 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 'The ReSPECT process – A guide for clinicians completing the plan' (Appendix A).

3.0 DEFINITIONS/ ABBREVIATIONS

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 and applicable, an ADRT refusing life sustaining 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.

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 they are 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 central pulse and regular breathing.
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 *'emergency treatment plans'*, 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 and 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 specific 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.
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. The document records recommendations about potentially life-sustaining treatments for a person, including a recommendation about CPR. The document may be referred to as ReSPECT plan, ReSPECT form or ReSPECT document, throughout the wider healthcare system.

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.

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 a 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 resident 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.

Resident Doctors
Commonly the decision is instigated by a resident doctor below ST3 level. If they are less senior than ST3, they must refer to a senior colleague (ST3 or above) to endorse the decision. This can be in person or over the phone. Good practice dictates this should be documented on the ReSPECT form. In the event of clinical urgency e.g. cardiopulmonary arrest, the absence of a senior endorsing signature does not invalidate the forms recommendations.

Advanced Clinical Practitioners & Clinical Nurse Specialists
Decisions on ReSPECT can also be made by an Advanced Clinical Practitioner (ACP) or Clinical Nurse Specialist, who has undertaken ReSPECT training 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 and 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 at every ward or board round, at transfers of care or on 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, Clinical Escalation and Response Group (ClEAR) and ReSPECT Development Groups
It is these groups responsibility to continue to develop and monitor the compliance with the policy and ReSPECT document and report concerns to The Trust's Quality Committee .

5.0 APPROVAL

Following consultation, this policy has been approved by the Trust's General Palliative and End of Life Care Committee.

6.0 DOCUMENT REQUIREMENTS

6.1 Who should have a ReSPECT document?

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 B.

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.

ReSPECT is suitable for a broad spectrum of people, particularly those with (but not limited to):

- An existing illness (such as advanced organ failure, advanced frailty or advanced cancer)
- Life limiting illness
- Long term conditions
- Palliative diagnoses
- A risk of health crisis
- Complex health needs
- Critically unwell patients
- Recurrent hospital admissions
- Those who have requested it.

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), **OR FOR** those that would likely not survive CPR at all, **OR** survive it in a state they would not wish to be in**, OR FOR** someone for whom invasive or higher-level medical treatments are inappropriate.

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

If a clinician makes a DNACPR decision, other than in exceptional circumstances, that decision must always be communicated to the person (or representative(s) of a person who lacks capacity). Clinicians should never inform a family member with the expectation that they will then relay the information to the person. There must be a specific reason not to discuss these issues with the patient and those important 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(s)and 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 patient's involvement in the discussion will lead to physical or psychological harm. It is acceptable that discussions can cause a 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 perceive as reasonable may be 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 clinico-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 them have 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 with 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 C) 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 them to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because they make 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
- 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

The ReSPECT document should be completed legibly, in black ink. The language used must be concise, free from ambiguity and easily understood by anyone who may respond to an emergency, in any health or care setting. Abbreviations or acronyms should not be used. Detailed guidance on the completion of the various sections of the ReSPECT document may be found in 'The ReSPECT process – A guide for clinicians completing the plan' (Appendix A) .

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.

On occasion, a patient may present to SFHFT from other care settings (such as care homes) with a photocopy of their original ReSPECT document or a black and white version. It may be possible to validate a photocopy or black and white version of a ReSPECT document by consulting the patient's electronic community health record (locally this is SystmOne). Unless there is a reasonable suspicion of tampering, these should be accepted as valid and initiate the process to review the document on change of care setting and assess its relevance. An original ReSPECT document should then be completed, which supersedes the photocopy or black and white version.

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 are subsequent **significant** changes 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 amend a ReSPECT document. Whilst amendments to the document are acceptable, significant amendments should not be made to the document, to avoid it becoming illegible; instead, the document should be cancelled and a new one completed. Where amendments are made, 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. ReSPECT recommendations are not legally binding (unless supported by a legally binding ADRT), but aim to guide immediate decision-making by health and care professionals responding to the person in a crisis. The decision-maker should bear in mind that they should be able to give valid 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 the 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 or no longer remain realistic, 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, 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 patients 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 (or representative(s) of a person who lacks capacity) concerns if they arise. The speed of escalation and the expected response will be informed by 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. ACCU for ACCU 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 have not enabled an agreement to be reached.

6.10 Documentation and Communication

All discussions between medical personnel, the patient and those important to them must be documented clearly in the patient's medical records and ReSPECT document, 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 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 in black ink, by scoring a line and writing 'CANCELLED' across the diagonal breadth of the document, 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 CPR decision on the ReSPECT document to avoid any confusion around the CPR decision. If a change of CPR decision is needed on a ReSPECT document, it should be cancelled as above and a new ReSPECT document completed.

Amendments may be made to other recommendations recorded on the ReSPECT document if they are no longer correct, providing there is sufficient space on the document and all recommendations remain legible. Amendments must be signed and dated in the relevant section of the form and endorsed by completing 'Section 9. Form reviewed' on the document.

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. Any amendments should be discussed and reviewed with the person (or representative(s) of a person who lacks capacity) and where necessary (e.g. lack of space for amendments or when making significant changes) a new ReSPECT document should be completed.

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 their agreement, those important to them 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(s) 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.

Where the ReSPECT plan is part of a person's 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 document as part of the local Electronic Palliative Care Coordination System (EPaCCS). Where access to EPaCCS is not available the ReSPECT document can be shared through the discharge information to the GP or other community or health / social care providers. Where death of a person 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 documents 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 person. 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 those important to them 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 09:00-17:00 hours
- Out of hours magnets necessary to perform this task can be found on ward 23 and in the Emergency Department Resus Department
- For those patients who lack capacity, Clinicians must adhere to the guidelines outlined in the 2005 Mental Capacity Act during the decision-making process.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (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 documents that meet the quality standard set out in this policy and documentation	ReSPECT Development Group	Audit (quality) utilising RCUK ReSPECT audit guidance	Annually	Reporting to ReSPECT Development Group, with escalation to ClEAR where required
To assess the proportion of in-patients with active ReSPECT documents that meet the quality standard set out in this policy and documentation	EOLC Team/ Ward Auditors	Metrics Audit (monthly)	Monthly	Reporting to the ReSPECT Development Group Quarterly

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.

Existing mandatory training such as resuscitation (accredited Resuscitation Council courses), communication training 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, ReSPECT learning modules are available on The NHS England E-learning for Health website. You will need to register and then log in to have access. If you have any questions about access, please reach out to the team at E-learning for Health via https://support.e-lfh.org.uk/.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix D
- This document is not subject to an Environmental Impact Assessment, see completed form at Appendix E.

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

Association of Ambulance Chief Executives (published 6 April 2017) (April 2018) [Online]. Available at: ReSPECT - aace.org.uk (accessed 25th September 2024)

British Medical Association (BMA) (2016) [Online]. Available at:: Decisions relating to CPR (cardiopulmonary resuscitation) (bma.org.uk) (accessed 25th September 2024)

British Medical Journal (BMJ) Emergency care and resuscitation plans (Published 28 February 2017) (April 2018) [Online]. Available at: https://www.bmj.com/content/356/bmj.j813

Care Quality Commission (CQC) (2021). Protect, respect, connect – decisions about living and dying well during Covid-19 [Online]. Available at: 20210318_dnacpr_printer-version.pdf (cqc.org.uk) (accessed 25th September 2024)

Compassion in Dying (2024) [Online]. Available at: What people need from a DNACPR decision and discussion – Compassion in Dying (accessed 25th September 2024)

Court of Appeal Judgement R (David Tracey) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health, (2014) [Online]. Available at: https://www.judiciary.uk/wp-content/uploads/2014/06/tracey-approved.pdf (Accessed on 25th September 2024).

Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (2005) [Online]. Available at: The Mental Capacity Act (accessed on 25th September 2024)

General Medical Council (GMC) (2010) [Online]. Available at: General Medical Council (2010). Treatment and care towards the end of life: good practice in decision making. (accessed 25th September 2024)

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): A policy to support its use. NHS London Strategic Clinical Networks April. Version 19, (2017) [Online]. Available at: ReSPECT for patients and carers | Resuscitation Council UK (Accessed on 25th September 2024).

Resuscitation Council United Kingdom (2018) ReSPECT [Online]. Available at: www.resus.org.uk/respect/ (Accessed on 25th September 2024)

Resuscitation Council United Kingdom (2021) Resuscitation Guidelines [Online]. Available at: https://www.resus.org.uk/library/2021-resuscitation-guidelines (Accessed on 25th September 2024).

Resuscitation Council United Kingdom (2014 to 2021) [Online]. Available at: www.respectprocess.org.uk/ (accessed 25th September 2024)

Sherwood Forest Hospitals NHS Foundation Trust (July 2016), Decisions About Cardiopulmonary Resuscitation (CPR) [Online]. Available at: Your Guide to Decisions Relating to Cardiopulmonary Resuscitation (CPR) *July 2016* (Public Information leaflet accessible via the Resuscitation Department intranet site) (Accessed on 25th September 2024)

Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB) [Online]. Available at: https://www.bailii.org/ew/cases/EWHC/QB/2015/3250.html (Accessed on 25th September 2024).

Related SFHFT Documents:

- The Resuscitation Policy for Adult, Maternity & Paediatric Patients
- End of Life Care Intranet
- Mental Capacity Act (MCA) Policy.

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 – The ReSPECT process – A guide for clinicians completing the plan
- Appendix B - ReSPECT Form (representational copy) (updated version included)
- Appendix C – Additional Mental Capacity Act Assessment Form (representational copy) (updated version included)
- Appendix D – Equality Impact Assessment
- Appendix E – Environment Impact Assessment

APPENDIX A – The ReSPECT process – A guide for clinicians completing the plan

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The ReSPECT process - A guide for clinicians completing the plan

Before you start:

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

Section 1: "This plan belongs to"

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

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

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

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

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

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

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

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

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

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

Next, record freehand clinical recommendations on **specific interventions** that would or would not be wanted or clinically appropriate, and summarise the reason for these. This may include whether the person would want to be taken to hospital and in what circumstances. Include other relevant recommendations (e.g. whether they should be considered for intensive care, or for 'invasive' ventilation).
Complete this box clearly. Avoid jargon; use wording that will be easily understood by all who may respond to an emergency in any health or care setting.

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ReSPECT

Now, after discussion and agreement, sign in **ONE** of the boxes to indicate whether CPR attempts are recommended (or, in a child, whether a plan for modified CPR has been agreed). A recommendation about CPR should be discussed within the discussion of overall goals of care, along with an honest explanation of what treatments can realistically be expected to achieve those goals. Remember that clinicians **must** discuss a recommendation not to attempt CPR with the person concerned, unless it is thought that it will cause physiological or psychological harm; if you believe this is so, you must document your reasons in section 6 and in the person's health record.

Section 5: "Capacity for involvement in making this plan"

- Assume the person has capacity.
- If you suspect the person has an impairment or disturbance of mind or brain, you must test their capacity for each specific decision. If the person lacks capacity for a specific decision, or they cannot have capacity (e.g. they are unconscious), the decision must be made by following the requirements of capacity legislation.

Section 6: "Involvement in making this plan"

Select **A, B** or **C** as appropriate, or complete section **D**.

Select **D** – if there has been:

- no involvement of the person (adult with capacity or child with sufficient maturity and understanding) because you believe it would cause physiological or psychological harm.
- no involvement of family or other representatives of a person who lacks capacity, because you believe this impracticable or inappropriate (e.g. no contact details or you believe that contacting a frail family member in the middle of the night would place them at risk).
- no involvement of those with parental responsibility for a child.

Summarise your reasons here; document them fully in the clinical record, together with a clearly defined plan to involve the person and/or their representatives as soon as possible/appropriate.

Section 7: "Clinicians' signatures"

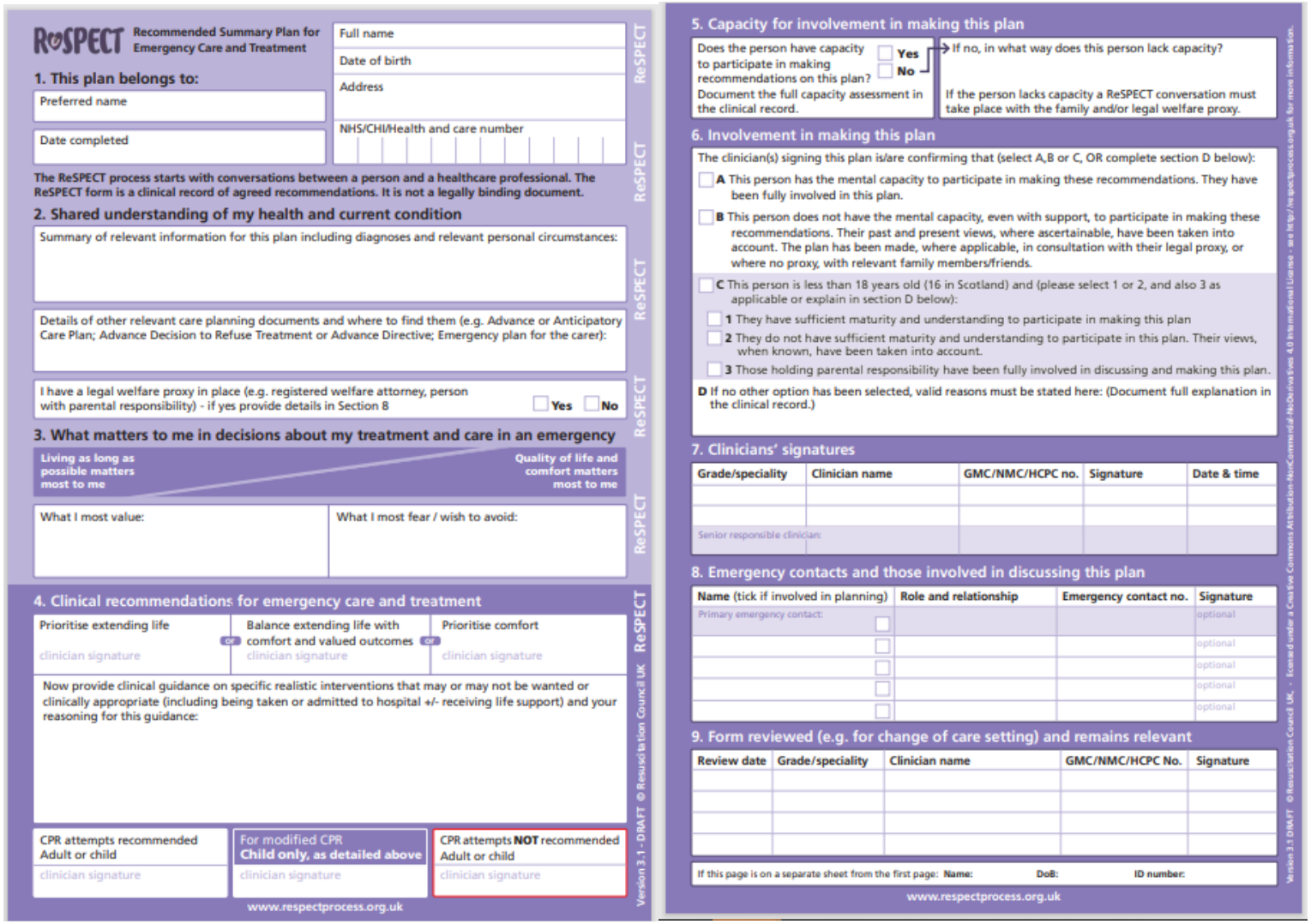
As the professional who completed the ReSPECT plan, you must sign this section and record the date and time. If you are not the senior responsible clinician, inform them of the plan and – at the earliest practicable time – they should review and endorse it by signing the shaded line (or – if appropriate – undertake further discussion and revision of the plan before signing it).

Section 8: "Emergency contacts and those involved in discussing this plan"

If they want to, let the person and/or those close to them confirm their involvement by signing here. Their signatures are optional. They do not make the plan legally binding. Record details of people to be contacted in an emergency. Remember that the plan is for use across all health and care settings.

Section 9: Plan reviewed (e.g. for change of care setting) and remains relevant

- Leave this blank at initial plan completion.
- Review may be prompted by a request from the person or their representative, by a change in their condition or by their transfer from one care setting to another. The responsible clinician should review the ReSPECT plan entries, and discuss the plan with the person themselves, unless to do so is justifiably unnecessary or would be harmful to them. If the recommendations are still appropriate, they should sign and date Section 9 to confirm this.
- If the recommendations are (or may be) no longer correct, they should be discussed and reviewed with the person (or representative(s) of a person who lacks capacity) and – where appropriate – a new ReSPECT plan should be completed.



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

1. This plan belongs to:

Full name
Date of birth
Address
NHS/CHI/Health and care number
Preferred name
Date completed

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 — clinician signature
OR
Balance extending life with comfort and valued outcomes — clinician signature
OR
Prioritise comfort — 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 — clinician signature

For modified CPR **Child only, as detailed above** — clinician signature

CPR attempts **NOT** recommended Adult or child — 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: ☐			optional
☐			optional
☐			optional
☐			optional
☐			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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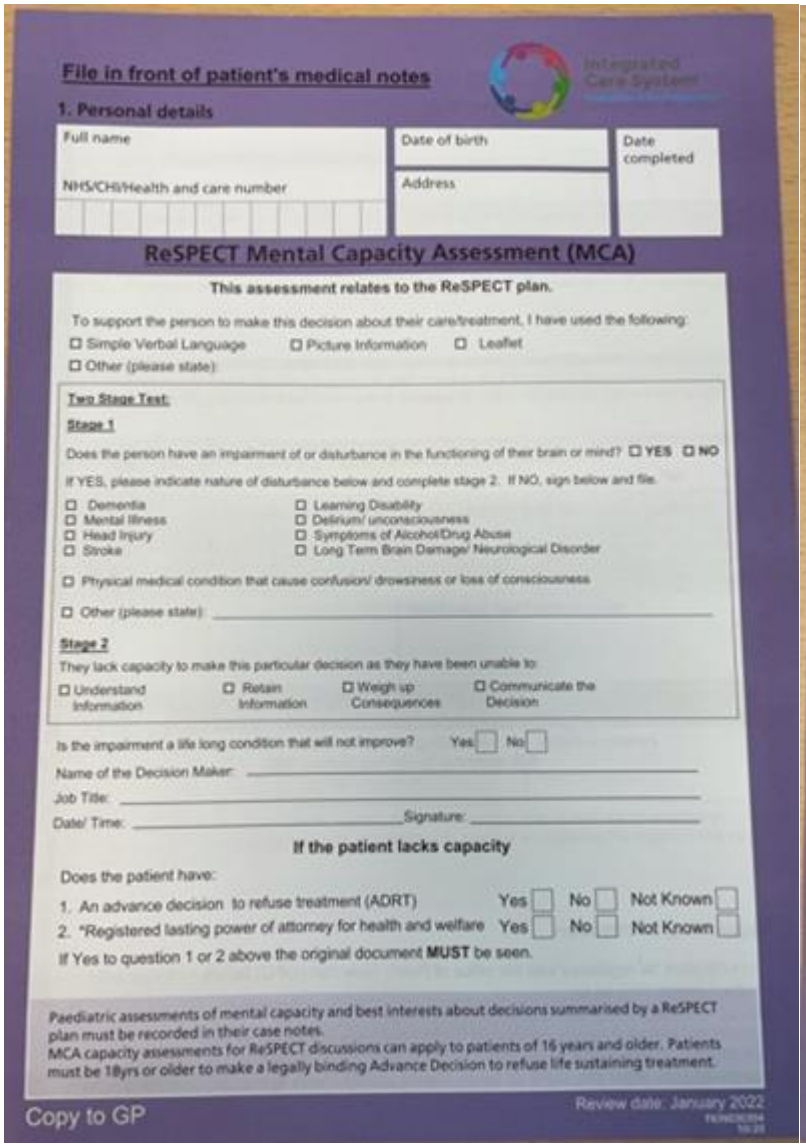
APPENDIX C – Additional Mental Capacity Assessment Form (Representational Copy)



File in front of patient's medical notes

Integrated Care System

1. Personal details

Full name	Date of birth	Date completed
NHS/CHI/Health and care number	Address	

ReSPECT Mental Capacity Assessment (MCA)

This assessment relates to the ReSPECT plan.

To support the person to make this decision about their care/treatment, I have used the following:

☐ Simple Verbal Language ☐ Picture Information ☐ Leaflet
☐ Other (please state):

Two Stage Test:

Stage 1

Does the person have an impairment of or disturbance in the functioning of their brain or mind? ☐ YES ☐ NO

If YES, please indicate nature of disturbance below and complete stage 2. If NO, sign below and file.

☐ Dementia
☐ Mental Illness
☐ Head Injury
☐ Stroke
☐ Learning Disability
☐ Delirium/ unconsciousness
☐ Symptoms of Alcohol/Drug Abuse
☐ Long Term Brain Damage/ Neurological Disorder

☐ Physical medical condition that cause confusion/ drowsiness or loss of consciousness

☐ Other (please state): _____

Stage 2

They lack capacity to make this particular decision as they have been unable to:

☐ Understand Information ☐ Retain Information ☐ Weigh up Consequences ☐ Communicate the Decision

Is the impairment a life long condition that will not improve? Yes ☐ No ☐

Name of the Decision Maker: _____

Job Title: _____

Date/ Time: _____ Signature: _____

If the patient lacks capacity

Does the patient have:

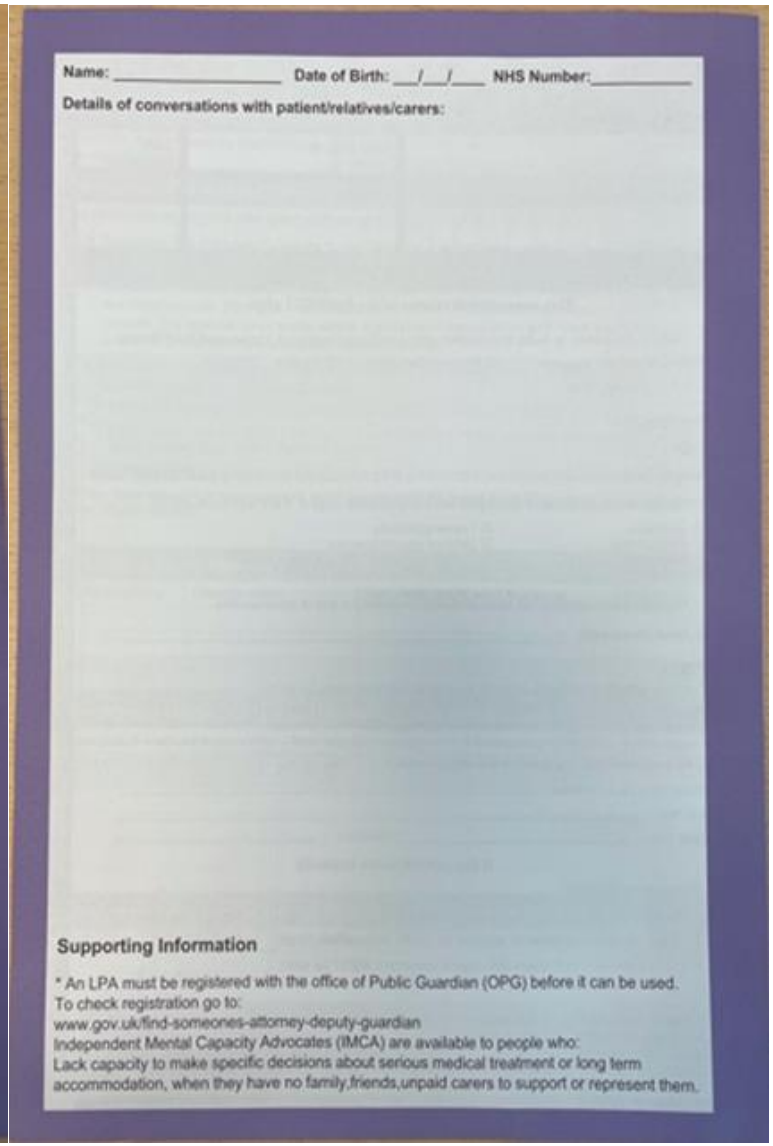
1. An advance decision to refuse treatment (ADRT) Yes ☐ No ☐ Not Known ☐
2. *Registered lasting power of attorney for health and welfare Yes ☐ No ☐ Not Known ☐

If Yes to question 1 or 2 above the original document **MUST** be seen.

Paediatric assessments of mental capacity and best interests about decisions summarised by a ReSPECT plan must be recorded in their case notes.
MCA capacity assessments for ReSPECT discussions can apply to patients of 16 years and older. Patients must be 18yrs or older to make a legally binding Advance Decision to refuse life sustaining treatment.

Copy to GP

Review date: January 2022



Name: _____ Date of Birth: __/__/____ NHS Number: _____

Details of conversations with patient/relatives/carers:

Supporting Information

* An LPA must be registered with the office of Public Guardian (OPG) before it can be used.
To check registration go to:
www.gov.uk/find-someones-attorney-deputy-guardian
Independent Mental Capacity Advocates (IMCA) are available to people who:
Lack capacity to make specific decisions about serious medical treatment or long term accommodation, when they have no family,friends,unpaid carers to support or represent them.

APPENDIX D – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Sherwood Forest Hospitals NHS Foundation Trust

New Policy: ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy			
Existing Policy: As above			
Date of Assessment: 30th August 2024			
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)			
Protected Characteristic	**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) 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?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	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.
Gender	N		
Age	N		
Religion/Philosophical Belief	N		
Disability	N		
Sexuality	N		
Pregnancy and Maternity	N		
Gender Reassignment	N		
Marriage and Civil Partnership	N		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	N		

What consultation with protected characteristic groups including patient groups have you carried out? • 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
What data or information did you use in support of this EqIA? • There has been a national process of formal consultation that took specific data and representative groups into account
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? • This policy seeks to positively reinforce these rights of patients and carers as well as those delivering treatment and care.
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: **Low Level of Impact** *(Delete as appropriate)* Similar policies have been successfully implemented in other Trusts nationally. For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment: Elizabeth Sansom Lead Nurse, End of Life Care
Signature: Elizabeth Sansom
Date: 30th August 2024

APPENDIX E – ENVIRONMENTAL IMPACT ASSESSMENT FORM

Sherwood Forest Hospitals NHS Foundation Trust

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.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • 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)	No	
Air	• 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.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	