Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

Unified Adult ReSPECT Policy

Policy for use across all providers in Bath and North East Somerset, Swindon and Wiltshire

In partnership with:

Avon and Wiltshire Mental Health Partnership NHS Trust
Bath and North East Somerset (BaNES) Council
BaNES, Swindon and Wiltshire CCG
Dorothy House Hospice
Great Western Hospital NHS Trust
Medvivo
Prospect Hospice
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust including Salisbury Hospice
South Western Ambulance Service NHS Foundation Trust
Swindon Community Healthcare Services
Virgin Care
West of England Academic Health Science Network
Wiltshire Health and Care
Wiltshire Council

BaNES, Swindon and Wiltshire – ReSPECT Policy Summary

This policy:

Applies to people over 18 years of age, under the care of BaNES, Swindon and Wiltshire (BSW) NHS organisations and / or Social Care Services

Summary points

- Advance decision making about care and medical treatment involves collaboration between a person and healthcare / social care professionals. In an emergency situation, it is vital that healthcare professionals have a clear understanding of any identified limitations in an individual's treatment (such as to withhold cardiopulmonary resuscitation [i.e.: do-not-attempt cardiopulmonary resuscitation (DNACPR) decision]).
- The ReSPECT form acts as a summary document for any key information that could influence emergency care at a time when a patient may not be able to express their wishes. This policy refers to decisions about a range of emergency care and treatment options. Such life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, and admission to intensive care unit (ICU) for intubation and ventilator support, inotropic and other cardiovascular support, as well as cardiopulmonary resuscitation (CPR).
- All significant treatment limitations must be clearly recorded on the ReSPECT form. This could include preferences about Critical Care admission, drug or other treatments – it is not limited to resuscitation decisions. **A ReSPECT form <u>may not always mean</u> do not attempt Cardiopulmonary Resuscitation (DNACPR).**
- **ReSPECT is not a legally binding document.** The ReSPECT form should be regarded as a summary of an advance clinical assessment with recommendations, recorded to guide immediate clinical decision-making in the event of a person's physical health deterioration or cardiorespiratory arrest. It constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'advance decision to refuse treatment'. The final decision regarding whether or not to attempt CPR or other life-sustaining treatment rests with the healthcare professionals responsible for the person's immediate care.
- A ReSPECT form does not replace additional detailed advance care planning documentation, such as Advance Decision to Refuse Treatment (ADRT) documents.
- It is the responsibility of the most senior registered healthcare professional in charge of a person's care, to review and endorse a completed ReSPECT form at the earliest opportunity following completion.
- Decisions to limit treatment must be discussed with the individual unless to do so would cause harm. Such decisions should also be discussed with those close to the person unless the person has indicated that this should not happen.
- Wherever possible original ReSPECT forms should be used. If that is not possible then a photocopied form will be accepted. It should be transcribed onto an original form at the earliest opportunity.
- **Healthcare providers, who are <u>uncertain</u> about the need to give life-saving care, should always presume to save life**. Emergency care should be given until any previously agreed limitations are clearly understood – this clarity is the purpose of the ReSPECT form.
- ReSPECT forms must be reviewed when a person's condition or wishes significantly changes, or when they are transferred / admitted / discharged from one healthcare provider to another.
- ReSPECT forms must stay with the individual so that healthcare providers can easily access them.

Gateway

Document Type	BaNES, Swindon & Wiltshire (BSW) Policy (system wide)
Unique Identifier	To be set by Web and Systems Development Team
Document Purpose	To provide clear guidance to health and social care professionals regarding the ReSPECT process, policy and forms across BSW
Document Author	Emma Frampton, Medical Director, Dorothy House Hospice Natasha Wiggins, Consultant in Palliative Medicine, GWH Clare Blakeley, Community Services Manager, Wiltshire Health and Care Policy adapted from Hereford and Worcestershire Health and Care Trust ReSPECT policy
Target Audience	Health and social care professionals
Responsible Group	BSW Palliative and End of Life Alliance
Date Ratified	BSW Palliative and End of Life Alliance Meeting 28 September 2021
Expiry Date	Review on a two-yearly basis, or sooner if required.

Version History

Version	Circulation Date	Job Title of Person/Name of Group circulated to	Brief Summary of Change
Draft v1	8 / 7 / 2021	Hannah Massey, Commissioning Manager, Wiltshire Locality Carol Gibson, Senior Quality Manager, Quality Lead for EOL	Initial draft written by Emma Frampton circulated to colleagues for initial comments and edits.
Draft v2	11/7/2021	Natasha Wiggins, Consultant in Palliative Medicine GWH Clare Blakely, Community Services Manager, Wiltshire Health and Care	Comments incorporated and sent to co-authors for initial comments
Draft v2	16/7/2021	ReSPECT working group members	Circulated amongst the group to collect comments
Draft v3	30/7/2021	Natasha Wiggins, Consultant in Palliative Medicine GWH Clare Blakely, Community Services Manager, Wiltshire Health and Care	Comments incorporated and sent to co-authors
Draft v4	2/8/2021	Emma Frampton, Medical Director Dorothy House Clare Blakely, Community Services Manager, Wiltshire Health and Care	Further comments and amendments sent to co-authors
Draft v5	4/8/2021	ReSPECT working group members	Further comments and amendments incorporated
Draft v6	09/08/2021	Natasha Wiggins, Consultant in Palliative Medicine GWH	Comments and amendments incorporated and circulated for final comment
Draft v7	13/08/2021	Natasha Wiggins, Consultant in Palliative Medicine GWH	Comments and amendments incorporated and circulated for comment
Draft v8	18/08/2021	Natasha Wiggins, Consultant in Palliative Medicine GWH	Comments incorporated and circulated for final approval.
Draft v9	20/08/2021	Natasha Wiggins, Consultant in Palliative Medicine GWH	Comments and amendments incorporated
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Draft V11	01/10/21	Natasha Wiggins, Consultant in Palliative Medicine GWH	Final document for formatting
Draft V12	04/10/2021	Wayne de Leeuw, CEO Dorothy House	Final document before formatting
V1.0	04/10/2021	Hannah Massey, Commissioning Manager, Wiltshire Locality	Final Draft converted to PDF

Abbreviations used

ADRT	Advance Decision to Refuse Treatment
BaNES	Bath and North East Somerset
BMA	British Medical Association
BSW	Bath and North East Somerset, Swindon and Wiltshire
CPR	Cardiopulmonary Resuscitation
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
EOLC	End of Life Care
GMC	General Medical Council
GWH	Great Western Hospitals NHS Foundation Trust
HDU	High Dependency Unit
ICU	Intensive Care Unit
LPA	Lasting Power of Attorney
NEWS	National Early Warning Score
NMC	Nursing and Midwifery Council
NOK	Next of Kin
RCN	Royal College of Nursing
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RUH	Royal United Hospitals Bath NHS Foundation Trust
SFT	Salisbury NHS Foundation Trust including Salisbury Hospice
SWAST	South Western Ambulance Service NHS Foundation Trust

Training and Development

BSW Health and Social Care partners recognise the importance of ensuring their workforce has every opportunity to access relevant training. Health and Social Care partners are committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by stakeholder organisations, across health and social care, are required to undertake the ReSPECT training that is relevant to their role and to ensure they meet their own continuous professional development requirements.

Co-production – Statement of Intent

Organisations expect that all health and social care professionals will provide clinical care in line with best practice. In offering and delivering that care, health and social care professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths.

It is important that patients are offered information on the treatment options being proposed in a way, that suits their individual needs, and that the health and / or social care professional acts as a facilitator to empower patients in a process of shared decision making which truly reflects choices which are right for them. It is also important that health and social care professionals recognise and utilise the resources available through colleagues and other organisations that can support patient health and wellbeing.

Contents

1. Scope of Policy

This policy has been ratified by Health and Social Care partners across BSW. These include:

a) Avon and Wiltshire Mental Health Partnership NHS Trust
b) Bath and North East Somerset (BaNES) Council
c) BaNES, Swindon and Wiltshire CCG
d) Dorothy House Hospice
e) Great Western Hospital NHS Trust
f) Medvivo
g) Prospect Hospice
h) Royal United Hospitals Bath NHS Foundation Trust
i) Salisbury NHS Foundation Trust including Salisbury Hospice
j) South Western Ambulance Service NHS Foundation Trust
k) Swindon Community Healthcare Services
l) Virgin Care
m) West of England Academic Health Science Network
n) Wiltshire Health and Care
o) Wiltshire Council

This policy applies to all health and social care professionals working within these organisations and can be used across the BSW Integrated Care System.

This policy applies to all adults in whom advance decisions relating to healthcare are being considered. For those at risk of deterioration or cardiac arrest, or those who want to have their wishes documented, a conversation regarding treatment options and focus of care should be held and a ReSPECT form, summarising the plan, completed. The aim of the ReSPECT process is to protect individuals and support health and social care professionals in making complex recommendations and to ensure all decisions/discussions are clearly recorded.

This policy has been written with reference to the latest guidance issued by the British Medical Association (BMA) / Royal College Nursing (RCN) / Resuscitation Council and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK).

2. Aims of Policy

a) To set out the principles which govern the use of the Recommended Summary Plans for Emergency Care and Treatment (ReSPECT).

b) To ensure that any decisions relating to a person's care and treatment, including Do Not Attempt CPR, are made with the person, or their representative, and are appropriate to the circumstance and include any limitations, with reference to:

i. The use of current national guidelines (Appendix 1).
ii. Compliance with the Mental Capacity Act 2005 as detailed in the national guidelines (Appendix 5).

iii. Clear documentation on the ReSPECT summary form (Appendix 2).
iv. Communication to all health and social care professionals involved in a person's care.
v. Regular review.

3. ReSPECT Principles

a) ReSPECT stands for **Re**commended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment. It is a widely used process and is recognised nationally, having been adopted in several Integrated Care Systems across the country. People in BSW will be able to transition from one care setting to another with all health and social care professionals recognising and endorsing ReSPECT.

b) The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency, including cardiac arrest, in which they do not have capacity to make or express choices. The process is intended to respect both individual preferences and clinical judgement. The agreed clinical recommendations that are recorded should include a recommendation on whether CPR should be attempted if the person's heart and breathing stop.

c) ReSPECT aims to promote more conversations between people (and / their families / carers) with clinicians, leading to shared decision making (when possible), better advance planning, good communication and documentation and better overall care.

d) For many people, anticipatory decisions about emergency care and treatment, including CPR, are best made in the wider context of advance care planning before a crisis necessitates a hurried decision in an emergency setting.

e) ReSPECT should be considered for those people who are at risk of a clinical deterioration that may place their life at risk. These people may already have an existing life limiting illness, such as advanced organ failure, or cancer.

f) The primary goal of healthcare is to benefit people, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the person, or if an adult with capacity has refused treatment, and documented accordingly when necessary, then that treatment is no longer justified (BMA, RC (UK) RCN 2007). Even potentially life-saving treatment can be withheld or withdrawn if it is not in the person's best interests and they lack capacity to make that decision at that time.

g) Cardiopulmonary resuscitation (CPR) is one treatment that has received much attention, and that has undoubted potential benefits for some people. However, CPR is often physically damaging (e.g., breaking ribs) and for many people there will be minimal or no chance of success, offering little or no benefit to the person receiving it. A person 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 in their situation.

h) Evidence suggests that when discussions have taken place about CPR in the context of overall goals of care; there is a reduction in the incidences of harm compared with focusing only on 'Do not attempt

cardiopulmonary resuscitation' (DNACPR) decisions and where harm does occur it is less severe.

i) 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'. They concern recommendations about 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.

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

k) 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 urgently, often when a person lacks mental capacity to make or contribute to making decisions at that time. Knowing what a person would have wanted keeps them at the centre of care, even when they may not be able to make their wishes known.

l) ReSPECT is not a legally binding document. The ReSPECT form is a summary of an advance clinical assessment with recommendations, recorded to guide immediate clinical decision-making in the event of a person's deterioration or cardiorespiratory arrest. It constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'advance decision to refuse treatment'. The final decision regarding whether to attempt CPR or other life-sustaining treatment rests with the healthcare professionals responsible for the person's immediate care.

m) Decisions documented on a ReSPECT form **do not** override clinical judgement. In the unlikely event of a reversible cause of the person's deterioration that does not match the circumstances envisaged when those decisions were made and recorded then the ReSPECT form may be overridden. Examples may include choking, a displaced tracheal tube or a blocked tracheostomy tube, anaphylaxis, and other unforeseen and potentially reversible causes.

n) An Advance Decision to Refuse Treatment (ADRT) is the only legally binding form of documentation in relation to the cessation of treatment for a person. If the individual has one of these it should be referenced on the ReSPECT form and if possible, attached to the form.

4. What is a ReSPECT conversation?

a) The emergency care summary plan is created through conversations between a person, or their LPA or named NOK if they are lacking capacity, and one or more of the health professionals who are involved with their care.

b) A ReSPECT conversation follows the ReSPECT process by:

i. Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future
ii. Identifying the person's preferences for and goals of care in the event of a future emergency
iii. Using this information to record an agreed focus of care as being more towards life-sustaining treatments or more towards prioritising comfort rather than efforts to sustain life
iv. Making and recording shared decisions about specific types of care and realistic treatment that the person would want considered, or that they would not want, and explaining sensitively advance decisions about treatments that clearly would not be successful in their situation
v. Making and recording a shared decision about whether CPR is recommended

c) The plan should **stay with the person** and be available immediately to health and social care professionals faced with making immediate decisions in an emergency in which the person has lost capacity to participate in making those decisions.

d) Advance decisions must be made based on an individual patient assessment and in consultation with the person, save in the exceptional circumstance that consultation is likely to cause physical or psychological harm to that person. The reason(s) not to consult with the person must be recorded in the patient record.

e) ReSPECT may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, an education setting, a hospice, or a hospital. Professionals such as ambulance crews, out-of-hours health care professionals, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to an agreed plan and clinical recommendations on a ReSPECT form.

5. To whom does this policy apply?

a) This policy applies to all adults in whom advance decisions relating to both physical and mental healthcare are being considered. If the person in question is not an adult, please refer to your local most appropriate policy for Children and Young People.

b) This policy is intended for all adults, below is a list (although not exhaustive) where a ReSPECT conversation and form may have more relevance.
i. with particular health needs that may involve a sudden physical deterioration in their health
ii. with a life limiting condition, such as advanced organ failure, advanced cancer, or frailty
iii. who are likely to be nearing the end of their lives
iv. at risk of sudden events, such as epilepsy or diabetic crisis
v. at foreseeable risk of death or sudden cardiorespiratory arrest
vi. who want to complete the ReSPECT process and documentation for other reasons

c) Considering explicitly, and whenever possible making specific anticipatory decisions about, emergency care and treatment options, including CPR, is an important part of good quality care for any person who is approaching the end of life and/or is at risk of further deterioration and cardiorespiratory arrest

d) If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or

treatment episode, it is not necessary to initiate discussion about CPR with the person for whom the ReSPECT form is being completed. However, they may still wish to discuss other aspects of emergency care and treatment, so then a ReSPECT conversation may be appropriate.

e) This policy refers to decisions about a range of emergency care and treatment options. Such life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, and admission to an intensive care unit (ICU) for intubation and ventilator support, inotropic and other cardiovascular support, as well as CPR.

f) This policy applies to all the multidisciplinary health and social care teams involved in the individual's care.

6. Cardiopulmonary resuscitation (CPR)

a) For many years, there has been debate over the use and design of DNACPR forms, together with recognition of their limitations. The ReSPECT process was created following a systematic review of DNACPR decisions and documents by the Resuscitation Council UK. An approach that focuses only on withholding CPR in people who are dying or for whom CPR would offer no overall benefit has resulted in misunderstandings, poor or absent communication, particularly with individuals or their family, and poor or absent documentation. ReSPECT aims to encourage patient and family involvement in decision-making, to consider recommendations about CPR in the context of broader plans for emergency care and treatment, and to record the resulting recommendations on a form that would be used and recognized by health and care professionals across the UK.

b) CPR could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically CPR could be used on every individual prior to death. There will be some cases where attempted resuscitation following cardio-respiratory arrest will not be effective. There will also be some cases where attempted resuscitation following cardio-respiratory arrest is not in the person's best interests because the potential burdens are likely to outweigh any possible benefits. It is essential to identify peoples for whom cardiopulmonary arrest represents the terminal event in their illness, and for whom CPR is therefore inappropriate.

c) Making a decision not to attempt CPR or other life-sustaining treatment that has no realistic prospect of success does not require the consent of the individual or of those close to them. However, there is a legal requirement to inform either of them (or their LPA or named NOK if lacking capacity), unless impossible. The individual and those close to them have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate but wherever possible it is better to have discussed the options with the person.

d) Failure to make timely and appropriate decisions about life-sustaining treatment may leave people at risk of receiving inappropriate or unwanted attempts at CPR and other active treatments as they die. The resulting indignity, with no prospect of benefit, is not acceptable, especially when many would not have wanted such treatment had their needs and wishes been explored.

e) DNACPR recommendations relate only to the act of CPR (e.g., chest compressions, ventilations, and defibrillation) and do not in themselves place any limitations on other aspects of the person's care. The ReSPECT process encourages clinicians to explore other treatments and interventions and the goals of care with the person rather than make decisions about CPR in isolation.

f) It may be against the clearly stated wishes of the individual to attempt CPR. Such cases should be clearly identified, and health and social care staff involved in the person's care should be made aware of action to take in the event of cardio-respiratory arrest.

g) If a person with capacity refuses CPR and other life sustaining treatment, or a person lacking capacity has a valid and applicable Advance Decision Refusing Treatment (ADRT), specifically refusing a particular treatment, this must be respected. If a person has capacity but their condition is likely to decline, they should be encouraged to consider making an ADRT or appointing a Lasting Power of Attorney (LPA) for health / welfare to ensure their wishes are legally recorded and followed.

h) Every decision about CPR must be made based on a careful assessment of each individual's situation.

i) It is preferable that DNACPR recommendations will no longer be recorded on separate documentation including the Treatment Escalation Plan (TEP) form; ideally the recommendation will be recorded on a ReSPECT form only as anticipatory recommendations about CPR are best made in the wider context of advance care planning. This is an important part of good quality care for any person who is approaching end of life and/or is at risk of cardiopulmonary arrest.

j) Existing and valid DNACPR decisions recorded on DNACPR documentation/TEP form dated 4th October 2021 or before will be valid for up to a year. DNACPR decisions recorded on DNACPR documentation / TEP forms dated 4th October 2021 or before will remain valid until their annual review is due. If you need to write a new form, then you must no longer use TEP/DNACPR but write it on a ReSPECT form instead. There is no need to actively change pre-existing forms as a matter of course unless clinically indicated or due review. The old DNACPR / TEP form must then be cancelled but should refer to the now completed ReSPECT form to avoid confusion as to the person's DNACPR status and filed in the patient health record.

k) All new DNACPR decisions from 4st October 2021 are to be recorded on a ReSPECT form as part of a ReSPECT conversation.

l) Medical emergencies where a DNACPR decision is required in isolation: The resuscitation recommendation can be signed on the ReSPECT form and the reason for this recommendation in isolation recorded. A wider ReSPECT conversation with the individual or representative should be commenced as soon as reasonably able.

m) In most cases there should be a presumption in favour of attempting resuscitation unless a valid and applicable DNACPR decision has been made. However, in appropriate circumstances with evidence of clear clinical decision making a decision not to start CPR will be supported.

n) Similarly, other life-sustaining treatments may be futile for those dying of a terminal condition, as

they would not reverse the underlying cause of the decline. It may then be appropriate to consider making decisions to avoid CPR and other life-sustaining treatments, to ensure that when death occurs there is no added loss of dignity. It is also essential to identify those people who would not want such treatments to be attempted in the event of deterioration in their condition and who competently refuse these treatment options.

o) If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and that CPR or other life-sustaining treatment would not be effective, CPR should not be attempted.

p) A decision-making framework relating to CPR, based on the "Resuscitation Council UK (2016) Decisions relating to cardiopulmonary resuscitation" guidance, is included in Appendix 3.

7. ReSPECT in practice

a) Every decision about emergency care and treatment options must be made on the basis of a careful assessment of each individual's situation and wishes.

b) Communication and good record keeping are central to the safe and effective use of the ReSPECT tool.

c) The Resuscitation Council (UK) / RCN / BMA Guidance Decisions relating to cardiopulmonary resuscitation (2016) provide general guidance on deciding when and how approaches to individuals and relatives should be made. The circumstances of each person should be considered, and a plan formulated on a case-by-case basis.

d) Discussions around emergency treatments should be undertaken sensitively. Clinicians should be responsive to verbal and non-verbal communication signals from the individual which may indicate the extent to which they wish to be involved in these discussions.

e) During such discussions, staff should explore treatment options and goals of care (e.g. referral to ICU, HDU, antibiotics and NEWS scoring etc.) which are relevant to the individual. Recommendations limiting other aspects of care must be clearly and explicitly recorded in the medical record and communicated to the multi- disciplinary team.

f) Clear and full documentation of decisions about life-sustaining treatment, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This will require documentation in the health record of detail beyond the content of a specific ReSPECT form.

g) For non-English speaking individuals and families, to ensure an informed decision can be arrived at, an interpreter will be required. It is **not** good practice to use relatives as interpreters. To obtain interpreters follow local procedures.

h) People with Learning Disabilities, communication difficulties including speech, sight or hearing impairment should have facilities provided to ensure their understanding wherever possible.

i) ReSPECT recommendations should be recorded on the **nationally recognised form** (Appendix 2) which should be filed according to trust guidelines to support timely accessibility and person-centred care. When the person is not in hospital the form should be kept somewhere accessible to all. All sections of the form should be completed, and an entry should be made in the healthcare records providing the rationale for the decision by documenting all relevant discussions held with the individual and any relevant others.

j) ReSPECT forms must remain with the person. They must be reviewed upon discharge from a clinical setting and ensure the person is advised to keep the document in a safe and visible place that carers, family and friends are aware of to ensure this is accessible in the event of an emergency.

k) Within the BSW region, ReSPECT forms can be uploaded to a digital End of Life Integrated Care Record and a clear, legible, uncropped image on this platform or as a photograph on a personal device e.g. mobile telephone, tablet, laptop is a valid and acceptable format in the absence of the paper form.

l) Avoid copying ReSPECT forms where possible. When copies are required, they need to be clearly marked "COPY". If greeted with two forms, to use the information on the most recent form.

m) ReSPECT must be reviewed regularly. A review will be required:
   i. Whenever significant changes occur in the person's condition
   ii. If there is a change in the person's expressed wishes
   iii. Whenever the person is admitted, discharged, transferred from one healthcare provider to another or moved on or off a caseload.

   The frequency of review should be determined by the health professional in charge of the person's care and will be influenced by the clinical circumstances of the person. Prior to changing/cancelling the ReSPECT, a discussion should take place with the person/family and amongst the multidisciplinary team including the most senior person responsible for the person's care. ReSPECT forms that are no longer valid should be clearly marked "CANCELLED" with two diagonal lines, your legible signature (and legible name and registration number) and the date.

n) ReSPECT covers hospital and community care episodes, including all health and social care professionals within BSW.

o) Following transfer between healthcare settings, ReSPECT decisions remain valid but should be verified as soon as possible by the clinician with overall responsibility for the person's care. The ReSPECT form (Appendix 2) should be used and accepted by all providers across BSW.

p) It is possible that a person may have a DNACPR decision or other emergency care, and treatment plan documented on a different form. For example, they may have been transferred from a different county, an old version of the DNACPR form may have been used in error, or their DNACPR decision may have been documented in an Advance Decision to Refuse Treatment without an accompanying ReSPECT form. Unless there is a good reason to believe the decisions are not genuine or applicable, they should be accepted as valid until the decisions are reviewed by the person's responsible senior clinician and a ReSPECT conversation takes place and form completed.

q) If an original ReSPECT form is not available, it is acceptable to use a photocopied form. This must be transcribed onto an original form at the earliest opportunity.

r) Once made, all recommendations must be communicated effectively to the relevant health professionals.

8. Clinical Responsibility for ReSPECT recommendations

a) Anyone involved in the care of the individual can initiate the process, where this seems to be likely to be helpful. It does not have to be the GP or the hospital doctor and may, for example, be a district or specialist nurse involved in the person's care.

b) The most senior registered health care professorial currently in charge of the individual's care at the time the ReSPECT is made carries responsibility for that recommendation until the individual is formally transferred. Foundation year 1 doctors, in this context, should not be viewed as registered health care professionals as their registration is provisional.

c) The senior registered health care professional might include a suitably experienced senior nurse or registered health care professional. Such decisions should be made by the most senior member of the clinical team available and then endorsed by the Consultant grade doctor/GP at the earliest possible opportunity.

d) The senior responsible clinician should be prepared to discuss the recommendation for the individual with other health professionals involved in their care, including the person's GP. This is particularly relevant when formulating ReSPECT for outpatients or those being discharged from hospital care.

e) Where a ReSPECT conversation has been undertaken and documented by any appropriately trained health care professional, who does not have overall responsibility for the person's care, they should fill in and sign the form. It is their responsibility to ensure a discussion with the GP / consultant grade who can review and sign to endorse the form. This must be done at the earliest opportunity. The name of the responsible senior clinician the ReSPECT recommendations were discussed with should be clearly documented and their agreement confirmed.

f) Where no explicit decisions about CPR and other life-sustaining treatment have been considered and recorded in advance there should be an initial presumption in favour of active treatment.

g) Consensus amongst all those involved in the ReSPECT process and subsequent recommendation is the preferred aim. If consensus cannot be reached, a clear note of the reasons for the disagreement and the individual or individuals expressing the disagreement should be made in the patient record. Ultimately, the responsibility to complete the ReSPECT form rests with the most senior health care professional in charge of the person's care.

h) Where the clinical recommendation is challenged or an objection is raised about the ReSPECT form by an individual, every effort should be made to reach a resolution through sensitive discussions. If an agreement cannot be reached, a second opinion and or legal input may be necessary.

i) Guidance for clinicians on how to complete the various sections of a ReSPECT form can be found in Appendix 2. Further information for individuals, families, and members of the public, for young people, and for parents, can be found on the ReSPECT website at https://www.respectprocess.org.uk/.

j) For people who are being cared for within an Acute Hospital or Hospice within BSW, there is a requirement for the responsible senior clinician to review and endorse the form within 48 hours of the recommendation being recorded. They must countersign the form in the space provided. There is not a similar time-based requirement for GPs given the logistical difficulties this might present for people in the community, but where appropriate the GP may wish to countersign the form at the earliest opportunity to further confirm their agreement with the recommendation.

9. Situations where there is a lack of agreement

a) A person with mental capacity may refuse any treatment from a healthcare professional even if that refusal results in death and any treatment carried out against their wishes is technically an assault. In these circumstances, individuals should be encouraged to make an ADRT.

b) Should the person with capacity refuse CPR or any other form of life- sustaining treatment, this should be clearly documented in their healthcare records after a thorough, informed discussion with the individual, and any family members or others that they wish to be involved, has taken place.

c) A previous verbal request to decline CPR or other life-sustaining treatment should be considered when making a best interest decision once a person has lost capacity, even if this was not documented formally on a ReSPECT form or as part of an ADRT. The verbal request needs to have been documented in the person's healthcare records by the person who it is directed to and can be used to support clinical judgement.

d) Although individuals do not have a legal right to demand that healthcare professionals carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected wherever possible.

e) In the case of disagreement, a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought from the organisation's legal representatives.

10. Cancellation of emergency care and treatment decisions

a) If the person's clinical condition changes, the decision may be made to cancel or revoke the current ReSPECT form. If the form is cancelled, it must be crossed through with two diagonal lines in black ballpoint ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional, who will print their name and GMC / NMC number clearly underneath their

signature for purposes of validation.

b) The form should be immediately removed and filed in the correspondence section of the patient record. Cancelled ReSPECT forms must not be destroyed, as they are an important record of discussions and decisions.

c) It is the responsibility of the healthcare professional cancelling the ReSPECT form to communicate this to all relevant parties involved in the care of the individual.

d) Another conversation should take place with the person and/or their representatives, and a new ReSPECT form created where appropriate.

11. Temporary suspension of emergency care and treatment decisions

a) In some circumstances, there are reversible causes of deterioration in a person's condition, including cardiorespiratory arrest. These are either pre-planned or acute and it may be appropriate for some or all of the ReSPECT decisions to be temporarily suspended under these circumstances.

b) Pre-planned: Some procedures could precipitate a deterioration or cardiopulmonary arrest, for example induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations. Under these circumstances, the ReSPECT decisions should be reviewed prior to procedure and consideration made as to whether the decisions should be suspended. Discussion with key people including the individual and/or carer, if appropriate, will need to take place.

c) If a decision to temporarily suspend any aspect of the advance decision is agreed this should be recorded in full in the patient record, including the recommendation(s) suspended the reason for the suspension and the period of time to which it applies.

d) Where the person suffers an acute, unforeseen, but immediately life-threatening situation such as anaphylaxis or choking, CPR or other emergency care and treatment may be appropriate for the reversible cause.

e) After the event, the ReSPECT decisions should be reviewed and discussed with the individual and reinstated where appropriate.

12. Mental Capacity Act 2005 (MCA) and Mental Health Act 1983 (as amended 2007)

a) Under the Mental Capacity Act (2005), clinicians are expected to understand how the Act works in practice and the implications for each individual for whom emergency care and treatment decisions, including DNACPR, have been made. See appendix 5 for the Two Stage Test of Mental Capacity.

b) The following sections of the European Convention on Human Rights are relevant to this policy:

i. The individual's right to life (article 2)

ii. To be free from inhuman or degrading treatment (article 3)
iii. Respect for privacy and family life (article 8)
iv. Freedom of expression, which includes the right to hold opinions and receive information (article 10)
v. To be free from discriminatory practices in respect to those rights (article 14)

c) In addition, this policy takes heed of, and is compliant with, Tracey v Cambridge University Hospitals NHS Foundation Trust 2014 and Winspear v City Hospitals Sunderland NHS Foundation Trust 2015.

d) Where individuals are detained under the Mental Health Act, the provisions of this Act only apply to decisions about mental health treatment for a mental health condition. Capacity legislation applies to all other decisions. Therefore, for individuals detained under the Mental Health Act decisions about any other aspect of care including CPR and other forms of life sustaining treatment should be made with regard to the Mental Capacity Act. Detention under the Mental Health Act would not nullify decisions documented on a ReSPECT form, ADRT or advance care plan written about non-psychiatric conditions.

e) If the person has capacity to take part in the making of the recommendations, they must be involved fully with the process of making them. Many people want to have the support of family, friends, or carers in the discussion, and some may choose to have a family member or friend advise them on what decisions to make.

f) If the individual does not want their family or other carers to know about their condition or their decisions, they should make sure that the healthcare team knows about this so that their wishes for confidentiality can be respected.

g) If a person has capacity a DNACPR decision must be communicated to them unless the clinician feels the person will suffer harm if they are consulted – any rationale to this end must be clearly reasoned and documented. The fact that a person may find the topic distressing is not a reason to make it inappropriate to involve them.

h) If a person indicates that they do not wish to discuss emergency treatments and resuscitation, this instruction should be respected. Where a ReSPECT form is to be completed and there has been no discussion with the individual because they have indicated a desire to avoid such a discussion, this must be documented on the form and in the health records, with reasons given.

i) If a person lacks capacity to contribute to a decision about resuscitation, the assessment of capacity must be documented in their health records, and any decision must be made in the person's best interests and must comply with the Mental Capacity Act 2005.

j) In situations where a person lacks capacity and staff are unaware that a valid advance decision refusing CPR (which is relevant to their current condition) has been made, then a further check must be made to identify if the individual has appointed a Lasting Power of Attorney (LPA) for Health and Welfare or Court Appointed Deputy. Court Appointed Deputies have similar powers to those with Power of Attorney but are appointed for people who have never had capacity or have lost capacity

before appointing a LPA.

k) In situations where a person lacks capacity, and there is no ADRT and no LPA/ Court Appointed Deputy, the MCA states family or friends must be consulted with. They may be able to help by indicating what the person's previous wishes, beliefs and feelings were. There is also a legal duty to involve a NOK if practicable; however, they should not be made to feel responsible for the decision, which remains a clinical decision.

l) In situations where the person lacks capacity, there is no ARDT, no welfare attorney appointment and no appropriate family, friends, or other advocate to consult, then the MCA states an Independent Mental Capacity Advocate (IMCA)must be appointed. This however does not apply in the emergency where the person's death is imminent. For details of the IMCA service in BSW:

- Bath & North East Somerset: POhWER advocacy, on 0300 4562370 or pohwer@pohwer.net
- Swindon: Swindon Advocacy Movement; Tel: 01793 542266 or 542575: info@swindonadvocacy.org.uk
- Wiltshire: The advocacy people – https://www.theadvocancypeople.org.uk

13. Organ and Tissue Donation

Exploring a person's decision about organ and/or tissue donation should be seen as a usual part of end-of-life care (Ref 4). There are very few absolute contra-indications to organ donation, and even fewer to tissue donation, so the discussion about organ and/or tissue donation should always be considered. The dying person's decisions should be sought by collaborative working between the clinical team responsible for the person's care and the Specialist Nurse for Organ Donation (SN-OD) or the Specialist Nurse for Tissue Donation (SN-TD). Please refer to local policy for more details on this.

14. Deactivation of implantable cardioverter defibrillators

People with implantable cardioverter defibrillators (ICD) may later develop terminal illness due to worsening of their underlying heart disease or other chronic non-cardiac disease. Terminally ill people are more likely to develop conditions such as hypoxia, sepsis, pain, heart failure and electrolyte disturbances, predisposing them to tachyarrhythmia's and thus increasing the risk of shock therapy. Shocks can be physically painful and psychologically stressful without prolonging a life of acceptable quality, a result that is clearly inconsistent with comfort care goals.

Furthermore, near the end of life, people may either not wish to undergo CPR or CPR may not be medically appropriate, therefore it becomes appropriate to consider ICD tachyarrhythmia's therapy deactivation when the person's clinical status worsens, and death is near.

In the end-of-life setting, discussions about deactivating ICD tachyarrhythmia therapy must take place as early as appropriate to enable proactive care management to avoid unnecessary distress. Although deactivation is not a complicated process, it may only be possible at certain times, because of the specific programmer required and technician support, therefore early planning is required.

Criteria for deactivating a defibrillator must be discussed with the person and/or their next of kin when resuscitation issues are explored or when a person's condition is worsening, and deactivation may be appropriate. Ideally, discussions must take place while the person is still able to be involved in the

decision-making process. If this is not possible, discussions must take place with the next of kin and/or Health and Welfare Lasting Power of Attorney, considering the known wishes of the person, ongoing medical treatments, and, if available, the details from an advance healthcare directive alongside consideration of what decision would be in the person's best interest.

When discussing the expectations of deactivating ICD tachyarrhythmia's therapy, the following must be made clear:

I. The device will no longer provide lifesaving therapy in the event of a ventricular tachyarrhythmia.

II. Turning off the device will not cause death.

III. Turning off the device will not be painful, nor will its failure of function cause pain.

IV. There will be a plan of care to ensure healthcare professional availability to address new questions or concerns.

V. The ICD will continue to provide bradycardia pacing should the person need it.

VI. The decision to deactivate the device can be reversed if the clinical situation changes. I.e. this is not an irreversible decision.

VII. A deactivation request form will need to be completed.

Please refer to your local policy for deactivation advice and guidance.

15. Relatives witnessing cardiopulmonary resuscitation

If the person's relative(s) requests to witness a resuscitation attempt it is the decision of the team leader and others present as to whether this is safe and appropriate.

Under no circumstances should a relative be left unsupported or unsupervised whilst witnessing a resuscitation attempt. It is essential that they are given the correct support and allowed the opportunity to leave or return when they feel it necessary.

Under no circumstances should relatives be coerced or encouraged to witness resuscitation if they have requested not to.

If a person or relatives have witnessed a cardiopulmonary resuscitation attempt on another person whilst an in-patient, they should be offered support and the opportunity to discuss the event.

16. Monitoring Compliance and Effectiveness of Implementation

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
100% compliance with the ReSPECT document compliance against policy.	ReSPECT Documentation Audit.	Resuscitation Department/ Clinical Audit.	Annual.	Local Resuscitation Committee Clinical Managers Medical/Patient Quality Committee.	Action plan written and communicated to relevant employees. Review education and training associated with this issue. Re-audit of non-compliant areas

17. Guidance

a) Guidance has been developed by the Resuscitation Council (UK): Recommending standards for recording "Do not attempt resuscitation" (DNAR) decisions (2021) https://www.resus.org.uk/library/quality-standards-cpr/quality-standards-acute-care#11-decisions-relating-to-cardiopulmonary-resuscitation

b) Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (Last updated June 2016

c) Decisions relating to Cardiopulmonary Resuscitation is available at https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/.

d) Further information about ReSPECT is available at https://www.respectprocess.org.uk/ Or https://www.hacw.nhs.uk/respect/

18. Glossary

Advance Care Plan (ACP)
An Advance Care Plan is a structured documented discussion with individuals and their families or carers about their wishes and thoughts for the future. It is a means of improving care for people, usually those nearing the end of life, and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. An ACP is likely to contain information about personal preferences (e.g. place of care preferences, funeral plans, understanding prognosis).

Capacity
Capacity means the ability to make and express a decision in relation to a particular matter. To have capacity a person must be able to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision and to communicate that decision (whether by talking, using sign language or any other means). If their mind is impaired or disturbed in some way, making and communicating decisions may not be possible. A person may lack capacity temporarily or permanently. However, a person should be assumed to have capacity for a decision unless or until it has been shown that they do not.

Cardiopulmonary Resuscitation (CPR)
Cardiopulmonary Resuscitation includes all the procedures, from basic first aid to advanced medical interventions, that can be used to try to restore the circulation and breathing in someone whose heart and breathing have stopped. The initial procedures usually include repeated, vigorous compression of the chest, and blowing air or oxygen into the lungs to try to achieve some circulation and breathing until an attempt can be made to restart the heart with an electric shock (defibrillation) or other intervention.

Children and Young People
In law, a child is anyone under the age of 18 years. Parental responsibility persists until a child is 18, but a child can attain competence to make decisions for themselves (Gillick competence) according to their age and maturity and, once they are 16 years old, are assumed to have capacity to make their own decisions like an adult. In this document, the term “children and young people” is used to refer to anyone under the age of 18, but the law in this area is complex, particularly with regards to those who are 16 and 17.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Do Not Attempt Cardiopulmonary Resuscitation decisions have also been called DNR, DNAR or ‘Not for Resuscitation’ (NFR) decisions or ‘orders’. They refer to decisions made and recorded to recommend that CPR is not attempted on a person should they suffer cardiac arrest or die. The purpose of a DNACPR decision is to provide immediate guidance to health or care professionals that CPR would not be wanted by the person or would not work or be of overall benefit to that person. This tries to ensure that a person who does not want CPR or would not benefit from it is not subjected to CPR and deprived of a dignified death or, worse still harmed by it.

Intensive Care Unit (ICU)
Intensive Care Unit is also referred to as Intensive Therapy Unit (ITU). This is the area in a hospital that provides sophisticated monitoring and equipment to assess and support the function of a critically ill

individual's vital organs, such as the lungs or kidneys or heart and circulation (e.g. a ventilator to help with breathing) until, whenever possible, they recover.

Mental Capacity Act (MCA)
The Mental Capacity Act (MCA) is legislation designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
ReSPECT is the first nationwide approach to discussing and agreeing care and treatment recommendations to guide decision-making in the event of an emergency in which the person has lost capacity to make or express choices. This process can be used by people of all ages.

Resuscitation
Resuscitation is general term used to describe various emergency treatments to correct life-threatening physiological disorders in a critically ill person. For example, 'fluid resuscitation' is rapid delivery of fluid into the bloodstream of a person who is critically fluid-depleted. Rapid blood transfusion for someone with severe bleeding is another example. Cardiopulmonary resuscitation (CPR) is sometimes referred to as 'resuscitation' but is a specific type of emergency treatment that is used to try to restart the heart and breathing.

19. References

- Advance Decision to Refuse Treatment, a guide for health and social care professionals. London: Department of Health.
- British Medical Association, (2000). The impact of the Human Rights Act 1998 on medical decision-making. London, BMA Books.
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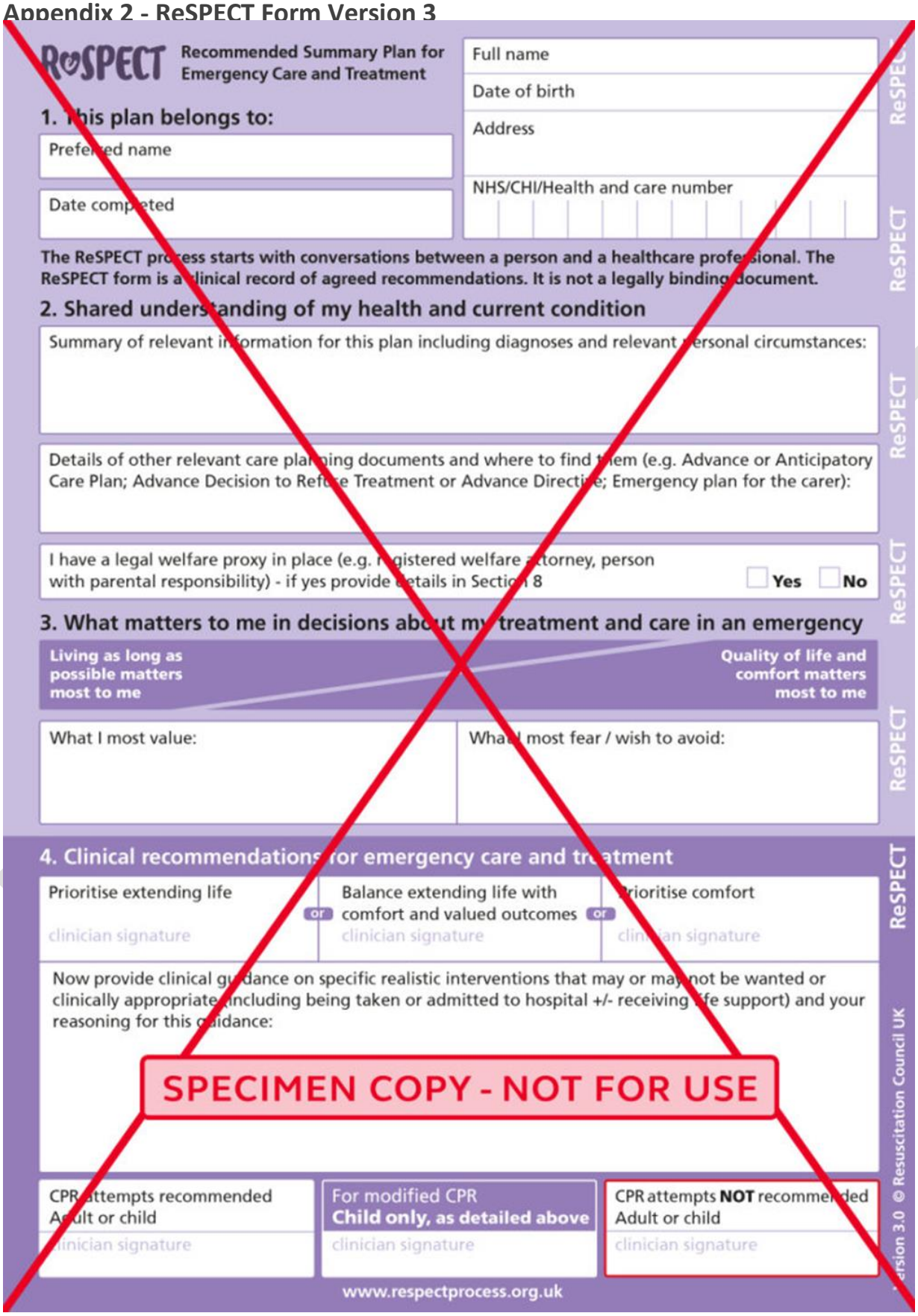
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland 2010.
- GMC Treatment and Care Towards the end of life: good practice in decision-making 2010.
- Human Rights Act. (1998) London: Crown Copyright. www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1.
- Mental Capacity Act. (2005) London: Crown Copyright. www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1.
- ReSPECT: Recommended Summary Plan for Emergency Care and Treatment website available at https://www.respectprocess.org.uk.
- Resuscitation Council UK (2016) Decisions relating to cardiopulmonary resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') 3rd edition (1st revision) https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/.
- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): Unified Adult ReSPECT Policy. Herefordshire & Worcestershire, 2020.
- The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): A policy to support its use. NHS London Strategic Clinical Networks April 2017.
- Tracey v Cambridge University Hospitals NHS Foundation Trust and others [2014] EWCA Civ 33.
- Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy NHS South Central 2010.
- Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB)

Appendix 1 – Resuscitation Guidelines 2021

For the latest guidelines please follow:

2021 Resuscitation Guidelines | Resuscitation Council UK
https://www.resus.org.uk/library/2021-resuscitation-guidelines

Appendix 2 - ReSPECT Form Version 3



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name

Date of birth

Address

NHS/CHI/Health and care number

1. This plan belongs to:

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:

SPECIMEN COPY - NOT FOR USE

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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ReSPECT

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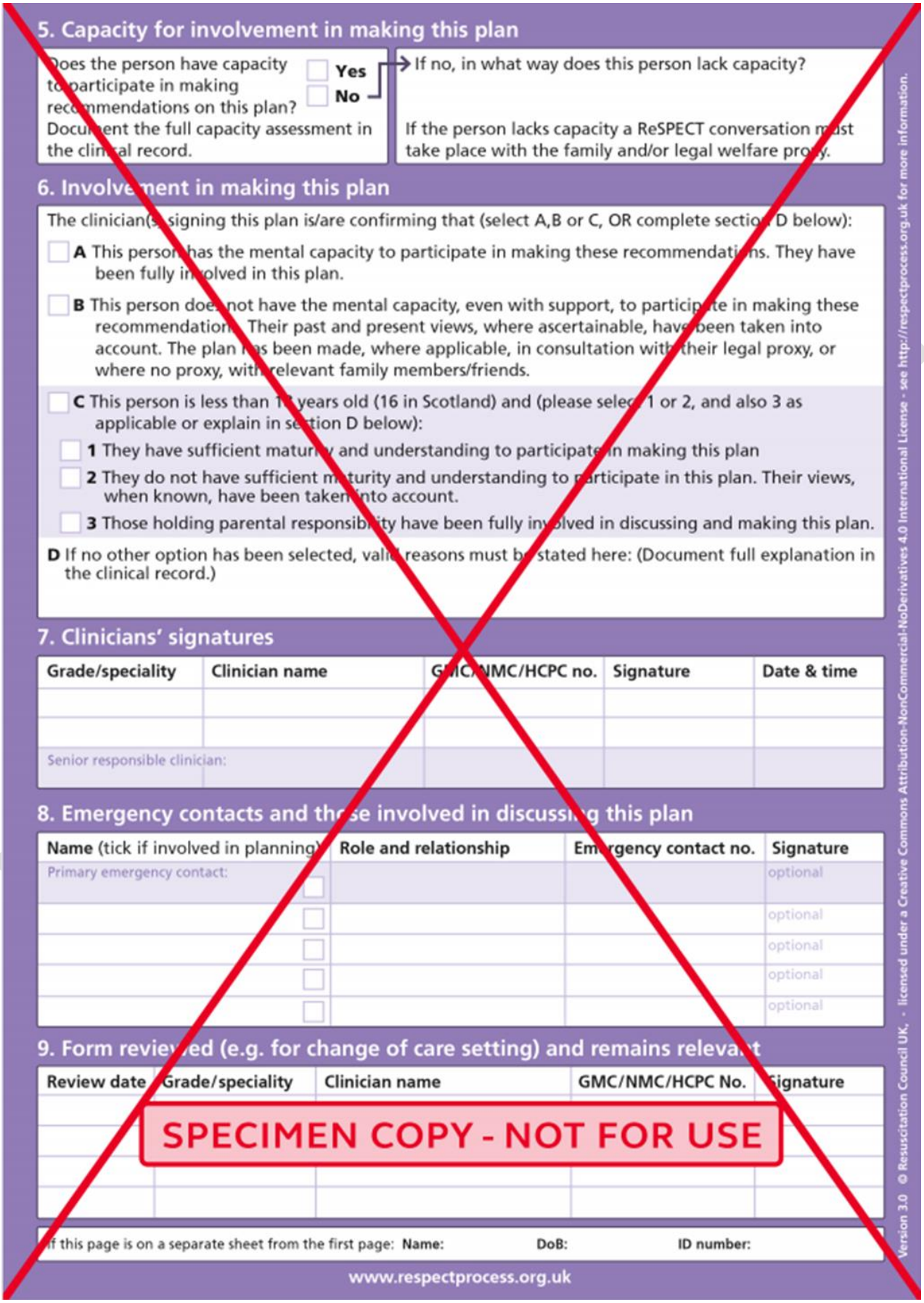

5. Capacity for involvement in making this plan

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

Document the full capacity assessment in the clinical record.

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

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

SPECIMEN COPY - NOT FOR USE

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

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Appendix 3 – Quick guide for clinicians

Resuscitation Council UK

ReSPECT

The ReSPECT process - A guide for clinicians completing the form

Before you start:

- Remember that completing the form is only part of the ReSPECT process.
- You can use the sequence of sections on the form to guide you through the conversation that is an essential part of that process.
- Do **not** complete the form 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 form 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 the person's likely wishes.
- Use the scale in section 3 to 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. If they want to, the person can mark the scale to show their current wish; do not pressurise them to do this.
- Explain that this plan is for use only when they cannot make decisions about emergency care and treatment. If they can make decisions, they can make choices at the time.

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.

ReSPECT guide for clinicians | updated March 2021 Page 1 of 2

Resuscitation Council UK

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 form, 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).

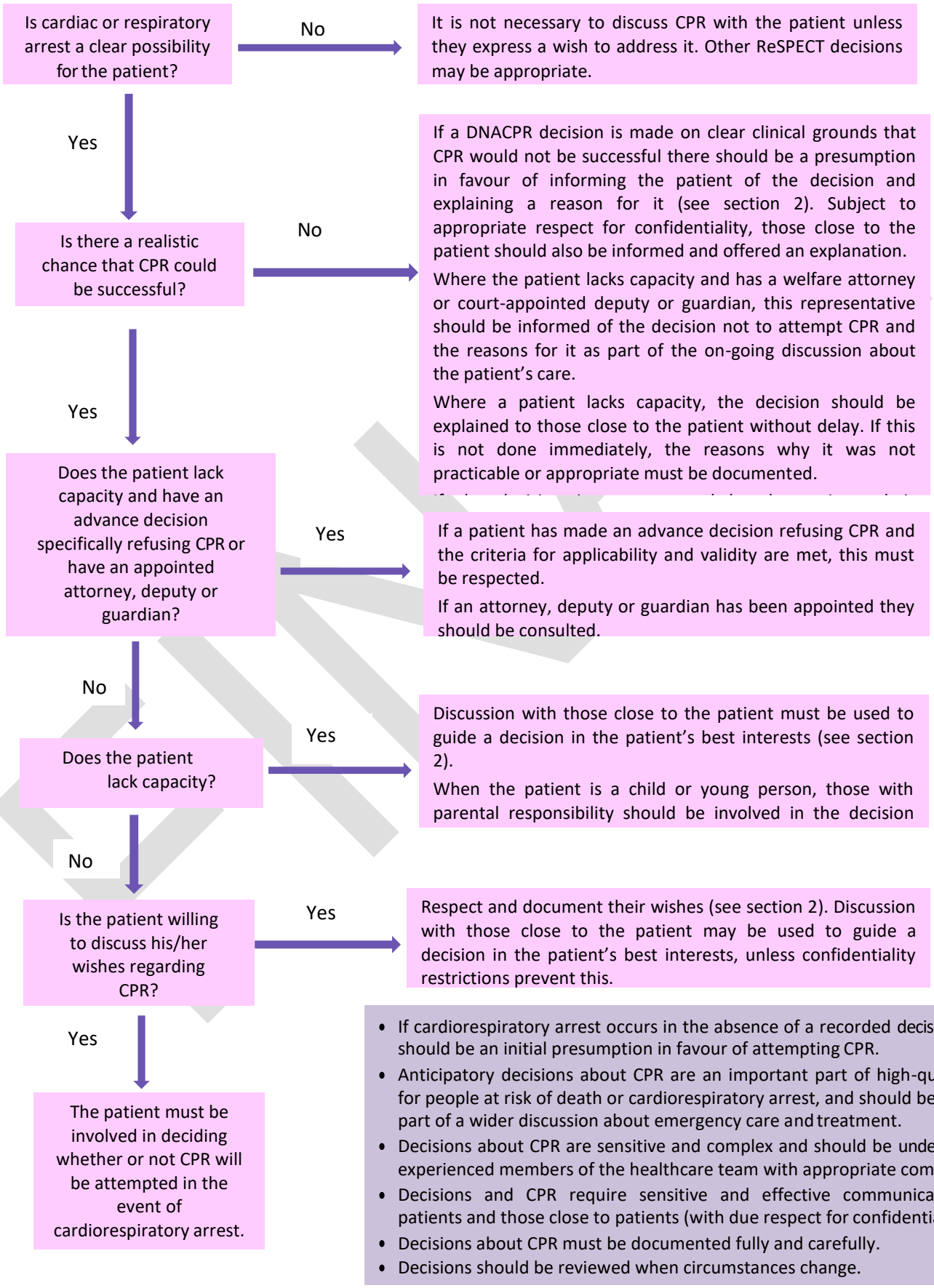
Section 8: "Emergency contacts and those involved in discussing this plan"

- 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 any more or less valid, or legally binding.
- Record details of people to be contacted in an emergency. Remember that the form is for use across all health and care settings.

Section 9: Form 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 form 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 form should be completed.

Appendix 4 – Decision-making framework for CPR



- If cardiorespiratory arrest occurs in the absence of a recorded decision, there should be an initial presumption in favour of attempting CPR.
- Anticipatory decisions about CPR are an important part of high-quality care for people at risk of death or cardiorespiratory arrest, and should be made as part of a wider discussion about emergency care and treatment.
- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.
- Decisions and CPR require sensitive and effective communication with patients and those close to patients (with due respect for confidentiality).
- Decisions about CPR must be documented fully and carefully.
- Decisions should be reviewed when circumstances change.

Appendix 5 – the Two-Stage Test of Mental Capacity

There is a two-stage test that must be used when assessing a person's Mental Capacity:

i. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain? (It doesn't matter whether the impairment or disturbance is temporary or permanent).
ii. Is the impairment or disturbance sufficient to cause the person to be unable to make a particular decision at the relevant time?