

London  
Strategic Clinical Networks

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

## **A policy to support its use**

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## 1. Introduction

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

However, recent advances cannot extend life, or stave off ill health, indefinitely.

Many people want to be able to influence the treatment that they receive, and take part in decision-making about treatment, whether currently in a state of ill health, or in anticipation of future ill health. For others who lack the mental capacity to make those decisions themselves, decisions about the treatment that they receive may have to be taken by others.

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

Recent attention has been given rightly to treatments other than CPR that may be relevant when people are seriously ill; recommendations about whether these treatments should or should not be given to a person are often referred to as 'emergency treatment plans' or 'treatment escalation plans' as they concern 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.

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

Increasing evidence suggests that considering a decision about whether or not to attempt CPR and discussing CPR in the context of overall goals of care and other types of care and treatment that might be needed leads to fewer, less severe harms compared to focusing only on 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions.<sup>1,2</sup>

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

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<sup>1</sup> Fritz et al, PLOS1 2013. 8(9):e70977

<sup>2</sup> Perkins et al, Health Serv Deliv Res 2016. 4(11)

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 that have been appointed to act on their behalf.

Documented evidence of a person's decisions or wishes is especially important and helpful to those who have to make decisions about potentially life-sustaining treatments. Many decisions that relate to emergency treatment need to be taken with urgency, often in a situation where a person lacks mental capacity to make or contribute to making decisions at that particular time. Knowing what a person would have wanted to happen to them keeps them at the centre of care, even when they may not be able to make their wishes known.

## **2. Development of the 'Recommended Summary Plan for Emergency Care and Treatment' (ReSPECT) document**

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process has been developed since October 2014, by a UK-wide group, which has been facilitated by the Resuscitation Council (UK) and the Royal College of Nursing. Its development was initiated following a systematic review of DNACPR decision-making<sup>2</sup> and in the light also of the NCEPOD 'Time to Intervene' report (2011), the Court of Appeal judgement in the case of *The Queen vs. Cambridge University Hospitals NHS Foundation Trust* ('the Tracey case'), the national guidance *Decisions relating to Cardiopulmonary Resuscitation* (BMA, RC (UK), RCN, 2014) and a growing demand for a national form for recording anticipatory recommendations about CPR and for a treatment-escalation-plan-style document.

ReSPECT is a process the aims of which are to promote more conversations between people and their clinicians about planning for future emergencies, to encourage high-quality, individualised, shared decision-making with people, including in particular those who are at risk of acute deterioration, and to promote high-quality documentation of such discussions and decisions. The ReSPECT process and documentation can be initiated and completed in any healthcare setting (acute, hospice or community); it can be shared between settings, and be valid across them, to ensure best care for the person wherever they may be.

The ReSPECT process is not solely aimed at decisions about limiting treatment; it is intended to support people to articulate and share their views about treatments and approaches to care that they *do* want, as well as about those that they don't. The process and document can cover recommendations about both specific treatments (such as clinically-assisted nutrition) and approaches to care (such as whether a person would want to be taken to hospital in an emergency).

## **3. Purpose of this Policy**

- To support the implementation of the 'Recommended Summary Plan for Emergency Care and Treatment' (ReSPECT) document across all healthcare settings. This policy should be read as integral to the use of that document.
- To acknowledge the centrality of people in decisions about the treatment that they receive, and to support shared decision-making between people and those providing care and treatment to them.
- To support the role of children, young people, those who care for them and those with Parental Responsibility in shared decision-making with those providing care and treatments
- To support advance care planning for those who choose to participate in this process, whether or not they have an advanced, progressive illness.
- To support the right of people aged 18 years and above to refuse, in advance, any treatment, even if that treatment is potentially life-sustaining. This right applies to adults with the mental capacity to refuse treatments in advance, in line with existing legislation.
- To support the legal requirement to treat those who lack mental capacity in relation to a particular decision, in their best interests. This extends to making decisions about potentially life-sustaining treatments on behalf of a person, including decisions about cardiopulmonary resuscitation (CPR).
- To provide a framework that guides healthcare professionals and providers, people, families and carers in making decisions and recommendations about potentially life-sustaining treatments, in line with good clinical practice and with 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, and not a replacement for more detailed advance care plans or for comprehensive documentation that includes details of discussions that have taken place. Such discussions must be documented in the relevant health and care record.
- To provide a policy that can and should be tailored to local healthcare governance processes and procedures, in such a way that maintains its substance.
- To provide a policy that complements, rather than duplicates, existing relevant local healthcare policies and procedures.

This policy supports fully the national guidance on CPR decisions published by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016) and the latest General Medical Council guidance (2010)<sup>3,4</sup>. This policy should be read in conjunction with that guidance. For young people age under 18 years the policy should also be read in conjunction with

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<sup>3</sup> Decisions related to cardiopulmonary resuscitation. Guidance from British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. 3<sup>rd</sup> Edition (1<sup>st</sup> revision) 2016.

<sup>4</sup> Treatment and care towards the end of life: good practice in decision making. General Medical Council 2010.

guidance from the Royal College of Paediatric and Child Health: 'Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice' 2015. This policy does not provide a guide to completing the different sections of the ReSPECT document; that guidance is contained within 'How to complete a ReSPECT form: Quick guide for clinicians' (please refer to appendix 2).

#### 4. Scope

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

In line with the ReSPECT process and documentation, this policy is applicable across all age groups, including babies, children and young people under the age of 18 years.

#### 5. Key principles of the ReSPECT document

The ReSPECT document:

- is relevant to decisions about **cardiopulmonary resuscitation (CPR), as well as decisions relating to other emergency and potentially life-sustaining treatments**, such as clinically assisted hydration and nutrition, assisted ventilation and intravenous antibiotic therapy (this list is not exhaustive).
- is intended to be **transferable** between, and valid in, all health and care settings, to avoid duplication, and to ensure that the person remains at the centre of decision-making wherever they may be.
- is **applicable** to all people of any age, whether or not they have an existing illness, or an advanced, progressive illness.
- does not remove the need to record discussions and rationale for decision-making in a person's current health record, in line with local procedures. Rather, the ReSPECT document is a **summary document** that facilitates recording and sharing of important information, and immediate clinical decision-making in a crisis.
- is intended to **replace** forms currently in use to record 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions and 'Emergency Treatment Plans' (see **glossary**) in all health and care settings. However, healthcare provider organisations may wish to retain specific detailed clinical guidance that relates to DNACPR decisions, insofar as it does not conflict with the processes covered by this policy; if other local guidance is retained, we recommend that that guidance is appended to this policy.
- does **not constitute** a legally binding refusal of treatment. It should be used as a guide to best-interests decision-making by healthcare professionals in an emergency setting, in relation to potentially life-sustaining care and treatments. As such, where it records the person's express preferences for their future care and treatment, it constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'advance

decision to refuse treatment (ADRT)' (please refer to the '**glossary**' section for further information).

- is intended to remain with and to be held **by the person**, and may be transferred also between any health and care professionals involved in a person's care. If person-held, a copy should be retained in the relevant health records. **Please note that a paper ReSPECT document should be treated as the active and current version of that document, unless there is good reason to think otherwise.**

## 6. Glossary of terms used within this policy

<b>Advance care planning (ACP)</b>	A voluntary process through which people can make decisions, or engage in planning about the care that they may be offered at a time when they lack capacity to give or withhold consent. ACP may take the form of stating wishes, preferences and values in an 'advance statement', and may include (in England & Wales) a legally binding refusal of a specific treatment. As such, it is broader than, but includes, 'emergency treatment planning' (see below). Please refer to the Mental Capacity Act 2005, and local policy, for further information.
<b>Advance Decision to Refuse Treatment (ADRT)</b>	A legally binding means (in England & Wales) through which a person aged 18 years and above, who has capacity to do so, may instruct that they should not receive certain treatments in certain circumstances if they lack mental capacity to decide for themselves at the time. To be valid, an ADRT must meet specific criteria. Please refer to the Mental Capacity Act 2005, and local policy, for further information.
<b>Advance statement</b>	An expression of a person's wishes, beliefs, values, or other information, made when a person has mental capacity to do so, that must be taken into account when decisions are being taken on behalf of a person who lacks mental capacity. Please refer to the Mental Capacity Act 2005, and local policy, for further information.
<b>Best interests</b>	<p>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 wishes and values of the person, and consultation with those close to them. Please refer to the Mental Capacity Act 2005, and local policy, for further information.</p> <p>For babies, children and young people under the age of 18 years, the term 'best interests' should be applied in the sense used in law (the five-point welfare check list of the Children Act 1989; the 9 point check list of the Mental Capacity Act 2005 as applied to over 16-year olds) and in published professional guidance (GMC End of life Care 2010; GMC 0–18 years: guidance for all doctors 2007). Determination of best interests involves balancing benefits and</p>

	<p>burdens of treatments and outcomes, whilst considering the ascertainable wishes, beliefs and values and preferences of the child and their family, the cultural and religious views of the latter, the views of those providing care for the child and what choice is least restrictive of future options. ('Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice' 2015)</p>
<b>Cardiorespiratory arrest</b>	<p>The cessation of cardiac output and spontaneous breathing. Unless this can be reversed by CPR, it will inevitably lead to death.</p>
<b>Consent</b>	<p>The process by which a person, or person with parental responsibility, with the mental capacity to do so accepts a treatment that is offered to them/their child. 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.</p>
<b>Cardiopulmonary resuscitation (CPR)</b>	<p>A term which refers to attempts made to restart the heart and provide breathing for a person in cardiorespiratory arrest. The chances of success vary, depending on several factors including the cause of the arrest and any underlying illness that the person may have. In English law, CPR is classed as a medical treatment.</p>
<b>Health records</b>	<p>Often referred to as 'medical notes' or 'patient notes', a person may have separate health records in different places of care. For example, a health record may be the GP's records for a person at home, or the hospital's 'medical notes' when the person is in hospital. The increasing use of digital records that are interoperable can facilitate transfer of information between different sets of records</p>
<b>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision</b>	<p>A 'decision' that CPR should not be attempted for a particular person. Unless the person (age 18 years and above) has recorded this in a valid and applicable ADRT (in England &amp; Wales) this is not, strictly speaking, a 'decision', but a recommendation to guide clinicians present at the time of a future cardiorespiratory arrest. It is those clinicians who must make the decision whether or not to attempt CPR. Such recommendations must be made in accordance with legal requirements, should follow good clinical practice, and should be documented clearly and correctly.</p>
<b>Emergency treatment decisions</b>	<p>The term often given to decisions about providing or limiting potentially life-sustaining treatments for a given person. Anticipatory decisions/recommendations about CPR are an example of emergency treatment planning. (see glossary entry for '<i>emergency treatment plans</i>', below.</p>
<b>Emergency treatment plans – also known as treatment escalation plans (TEPs)</b>	<p>The term given to a written record of a shared decision-making process about care and treatment in a future emergency situation'. A ReSPECT document is an example of an emergency treatment</p>



	plan.
<b>GP</b>	General practitioner. These are doctors in primary healthcare who are likely to have overall clinical responsibility for the care of a person outside of a hospital or hospice setting, and who are often the first point of contact for healthcare issues that are not immediately life-threatening.
<b>Healthcare professional with overall clinical responsibility – also sometimes referred to as the senior responsible clinician</b>	The healthcare professional involved in a person's care who is ultimately professionally responsible for a person's health care in a given setting. This person will also be professionally responsible for engagement in the ReSPECT process and ensuring the quality of documentation for that person. For example, in a hospital, this will usually be the named consultant.
<b>Healthcare setting</b>	A place where a person receives health care from a distinct healthcare team, or a distinct healthcare professional with overall clinical responsibility. For example, a hospital, a person's home, a hospice and a nursing home are all different healthcare settings.
<b>Lasting Power of Attorney (LPA)</b>	LPA can be given only by people aged 18 years and above. A person given this power under the Mental Capacity Act 2005, has the power and responsibility to make certain decisions on behalf of a person (the donor) if they have lost capacity to make or express those decisions. Only if an LPA gives decision-making power relating to 'health and welfare' can the attorney make decisions about a person's care and treatment. The attorney 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.
<b>Parental Responsibility (PR)</b>	<p>PR refers to the rights and responsibilities parents have in respect to their children. This includes decisions relating to medical care and its withdrawal (subject to such decisions being made in the child's best interests). The meaning and scope of PR is set out in the Children Act 1989.</p> <p>A child's biological mother automatically has PR. A biological father will only have PR if the birth was registered after 15 April 2002 in Northern Ireland, from 1 December 2003 in England and Wales, and from 4 May 2006 in Scotland, or if (prior to these dates) he was married to the mother at the time of the child's birth, or he has subsequently entered into a PR agreement with her, or obtained a court order granting him PR.</p> <p>PR is also held by fathers or second female parents named in Child Care arrangement Orders.</p>

	<p>Other individuals or organisations can obtain PR by court order, or by being appointed as a guardian on the death of a parent.</p> <p>(The Children and Families Act 2014. <a href="http://www.legislation.gov.uk">www.legislation.gov.uk</a>)</p>
<b>Potentially life-sustaining treatment</b>	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).
<b>Mental Capacity</b>	The ability to consider and make a decision about a particular matter at the time the decision needs to be made. A person with mental capacity can understand and retain the information relevant to the decision in question, weigh it up, and communicate their decision. Please refer to the Mental Capacity Act 2005, and local policy, for further information. The Mental Capacity Act applies to people age 16 years and above
<b>Mental Capacity Act 2005 (MCA)</b>	The law in England & Wales that stipulates how those who lack mental capacity must be treated. It applies to people age 16 years and above. In England and Wales, children aged 16–17 years are presumed to have capacity to consent to treatment (Family Law Reform Act 1969 s8), <b>but</b> they cannot refuse treatment that is considered to be in their best interests.
<b>Nominated deputy</b>	A healthcare professional with delegated clinical responsibility from the healthcare professional with overall clinical responsibility. The nominated deputy must have the knowledge and skills required. This may be, for example, a trainee doctor or a nurse.
<b>Provider organisation / healthcare provider organisation</b>	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.
<b>Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document</b>	The document supported by this policy. The ReSPECT document summarises information and recommendations about emergency care and treatment for a person in the event of their clinical deterioration and them having a lack of capacity at the time. The document records recommendations about potentially life-sustaining treatments for a person, including a recommendation about CPR.

## 7. Suggested local responsibility and ownership of this policy

This section is intended to assist local healthcare provider organisations to identify key lines of responsibility and ownership of this policy. It is expected that this section, in particular, will be tailored to local requirements, and may refer to an up-to-date list of relevant named individuals, included as an appendix to this policy.

To support the implementation and ongoing use of the ReSPECT document and of this policy, the following responsibilities should be addressed locally:

#### *Corporate/Legal responsibility*

The provider organisation should ensure that this policy is covered by existing structures and processes in place for corporate and legal responsibility of its usual activity.

#### *Executive responsibility*

The provider organisation should ensure that there is a named individual(s) with executive responsibility for this policy and the procedures and processes included herein. This may be the provider organisation's Medical Director, or equivalent.

#### *Governance responsibility*

The provider organisation may wish to support this responsibility through local committees such as a resuscitation committee, end-of-life care steering group, or equivalent.

This responsibility may entail having organisational oversight in relation to decisions about CPR, adherence to this policy, data on training and education, receipt of the results of regular auditing of this policy and use of the ReSPECT document within that organisation, and providing feedback of such local experience to the ReSPECT Working Group or equivalent. Additionally, the provider organisation should consider putting in place a process that ensures that relevant national developments are identified and acted upon.

The provider may also wish to appoint a named individual to act as a contact for other local providers in relation to any issues arising from the use of the ReSPECT document within the locality.

#### *Educational and training responsibility*

The provider organisation should ensure that it has one or more named individuals or a committee with responsibility for oversight of education and training in relation to the ReSPECT document and process, and in relation to this policy, alongside any existing training in advance care planning, decision-making about CPR, or emergency treatment plans. The training of all relevant staff groups, as determined locally, should be addressed under this responsibility.

The provider organisation may wish to share local educational resources across a healthcare system, where appropriate.

#### *Audit responsibility*

The provider organisation should ensure that it has one or more named individuals or a committee with responsibility for ensuring regular audit of adherence to this policy and the use of the ReSPECT document, to complement or incorporate any ongoing local CPR/DNACPR audits. This responsibility should also address reporting of the audit results to the relevant local governance committee (e.g. the resuscitation committee, or equivalent).

### *Clinical responsibility*

Each provider organisation may have several healthcare workers with individual clinical responsibility for those in their care to a lesser or greater degree; nothing in this policy detracts from that clinical responsibility. We recommend that each provider highlights this as part of their local education and training, and makes it explicit that the healthcare professional with overall clinical responsibility for a person's care will also be responsible for that person's ReSPECT document.

As part of the initial and ongoing implementation of this policy, each provider organisation should take steps to ensure that those with individual clinical responsibility are aware of their roles, of expectations arising therefrom, and of their practical implications.

The healthcare professional with overall clinical responsibility for a person's care in a given setting should be identified clearly. However, other members of the healthcare team may still be involved in the person's care, and may have responsibility for some aspects of care including (but not limited to): familiarisation with this policy and with the ReSPECT process, communication about the ReSPECT process, and including documentation, and decision-making when a person has a completed ReSPECT document. Any such responsibilities should be identified explicitly and supported, for example, through training.

## **8. The ReSPECT process in practice**

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

The ReSPECT document is intended to be a **replacement** for the many DNACPR and 'emergency treatment plan' documents that are currently in use in various healthcare settings.

The ReSPECT document addresses emergency care and treatment planning in relation to emergency, potentially life-sustaining treatment, including CPR. It should be considered for, but not limited to, those who are at risk of a significant clinical deterioration that may place their life at risk. Such people may already have an existing illness, such as advanced organ failure, or advanced cancer. As a minimum, it should be considered for any person that is at foreseeable risk of cardiorespiratory arrest, as is currently recommended for anticipatory decisions about CPR.

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

### *Making clinical decisions in an emergency situation*

The clinical responsibility for making emergency treatment decisions, including those in relation to CPR, rests with the most senior healthcare professional attending the person at the time that a decision must be made. This may be, for example, a GP, medical or nurse consultant, other doctor, nurse or paramedic, with the appropriate knowledge and skill to make these decisions. **Decisions must always be made in accordance with existing legal requirements, with good clinical practice, and with local policy.**

In the absence of a legally valid and applicable ADRT that refuses the treatment in question (including CPR), a decision must be taken in the best interests of the person whose treatment is being considered, if the person is unable to or does not wish to engage in discussions regarding treatment options. In this situation, a completed ReSPECT document is an aid to such decision-making. In case of uncertainty, there should be a strong, but not absolute, presumption in favour of providing treatment that is potentially life-sustaining. If in doubt, and the clinical situation allows, obtaining advice from a senior healthcare professional, from other healthcare professionals involved in the care of the person, and from those close to the person (such as family or friends) should be attempted, in line with legal requirements as stipulated in Section 4(7) of the Mental Capacity Act 2005 (see below). In the case of a person under the age of 18 years all attempts must be made to include the parents/person(s) with parental responsibility in any decisions.

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

A consultant, General Practitioner or their nominated deputy should use their clinical judgement about initiating discussions about CPR and other emergency treatment decisions. There must be a presumption in favour of discussing these issues with people over the age of 16 years who have the mental capacity to participate in such decision-making, and the threshold for not doing so is set high (i.e. a risk of physical or psychological harm to the person from having the discussion). This applies even if CPR is thought to have little or no chance of a successful outcome.

For all young people under the age of 18 years, The Children's Act and the United Nations Convention on the Rights of a Child (UNCRC) place emphasis on involving individual children, in accordance with their age and capacity, and giving due weight to their views in making informed determination of what is in the child's best interests. This is supported by GMC guidance that 'you should involve children and young people as much as possible in decisions about their care, even when they are not able to make decisions on their own'.

In England and Wales, young people aged 16–17 years are presumed to have capacity to consent to treatment, but they cannot refuse treatment that is considered to be in their best interests. A person under 18 years may only refuse life-sustaining treatment where parents and clinicians agree with that refusal and believe it to be in the young person's best interest. Where there is no such agreement, the child's refusal may be overridden by those with PR or by the Court if it is considered in their best interests to do so.

A healthcare professional has no legal duty to give a person a treatment that they judge to have no reasonable chance of success, or to be clinically inappropriate, including CPR. Furthermore, the national guidance on CPR decision-making recommends that where treatment has no realistic prospect of benefit, it should not be offered<sup>3</sup>. In such circumstances the presumption in favour of involving the person is considered to require careful and sensitive explanation of their condition and of the reasons why a treatment would not work or would be inappropriate in their situation.

Although recent case law refers principally to DNACPR decisions, the 'duty to consult' is recognised as a fundamental aspect of health care in relation to other treatments, and should be viewed as applying to decisions about other potentially life-sustaining treatments.

If there is a realistic chance that CPR would be successful, and the person has capacity, then the person must be involved in considering and making plans and recommendations concerning whether or not CPR should be attempted. In the case of a baby, child or young person aged under 18 years, this discussion should involve the parents/person(s) with PR and, where appropriate, the young person themselves.

The outcome of any discussions with the person and/or person(s) with PR regarding potentially life-sustaining treatments in an emergency situation should be summarised in the ReSPECT document, with further detail included in the person's current health record, in line with local policy.

If a person has not been involved, or does not wish to be included in discussions about potential life-sustaining treatments, including CPR, their agreement should be sought to involve those close to him or her in the decision-making process. Any discussions with those close to the person must be conducted in accordance with that person's right to confidentiality.

**If neither the person nor those close to him/her has been involved in decision-making, the reasons should be recorded clearly on the ReSPECT document and in the person's current health record.**

Such situations will present significant challenges to the provision of person-centred care, especially in a community setting. Care should be taken when considering whether, or how, to transfer a ReSPECT document or information relating to the challenges experienced, across settings. However, it is anticipated that these situations will not arise commonly. In the case of a young person aged under 18 years it should not be necessary to make a decision without consulting the parent/person(s) with PR.

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

Any person over the age of 18 years can give or withhold consent to any treatment offered to them, if they have the mental capacity to do so, so long as their decision is voluntary and adequately informed. This applies even if a decision concerns whether or not to undergo treatment that is potentially life-sustaining.

For anyone under the age of 18 years you should not withhold information about their diagnosis and prognosis that they are able to understand, unless they ask you to, or you judge that giving it might cause them serious harm. Under the age of 18 years, a young person should be involved in the decisionmaking process, in accordance with their age and capacity, and giving due weight to their views in making informed determination of what is in their best interests, even if they are not able to make decisions on their own. In England and Wales, those aged 16–17 years are presumed to have capacity to consent to treatment, but they cannot refuse CPR, unless parent(s)/person(s) with PR and clinicians agree with that refusal (and consider it to be in their best interest).

For young people under 18 years it is essential to include parent(s)/persons with PR in the decision making.

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 (to be determined in accordance with local policy).

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

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

The Mental Capacity Act 2005 (MCA) sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves, and applies to people age 16 years and over. The Act sets out five ‘statutory principles’ – the values that underpin its legal requirements:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.



For more information on the requirements of the Act please refer to the MCA, the MCA Code of Practice [<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>] and local policy. 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 his welfare,
- any donee of a lasting power of attorney for health granted by the person, and
- any deputy appointed for the person by the court,

unless it is not practicable or appropriate to consult them. For a young person under the age of 18 years, the parent(s)/person(s) with PR should always be included in the decision making process.

**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, as determined by local policy.**

### ***Completion of a ReSPECT document and record-keeping***

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

The ReSPECT document can be used in hard (paper) copy and electronically, according to local policy. 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. Where they have a digital health record, for example in general practice or in a hospital, the document may be stored digitally as well. Where digital and paper formats co-exist it is essential that any changes in the person's needs and preferences and in the recommendations on the ReSPECT document are recorded promptly on all available versions. A crucial aspect of ReSPECT is that it should be available to and easily accessible by the relevant healthcare professionals who may have to provide care and make immediate decisions in an emergency situation.



As the ReSPECT document is a summary of detailed conversations and planning that may have taken place on more than one occasion, it is essential that a comprehensive record of such is documented in the person's current health record, in accordance with local and national requirements. An entry in that record should also state the date and time of completion of the ReSPECT document.

If there is a subsequent significant change in the plan of care for a person, a new ReSPECT document should be completed and the old one clearly marked as cancelled and added to the person's current health record (see '**amending or cancelling a person's ReSPECT document**' section, below). An entry should also be made in the person's current health record stating the date and time that the document has been amended or cancelled and recording details of any new document completed. The healthcare professional with overall clinical responsibility is responsible for ensuring that this has been done.

In addition to (and on behalf of) those with overall clinical responsibility for the care of a person healthcare professionals who are involved in a person's care and who have appropriate knowledge and skills, may complete or amend a ReSPECT document. Amendments should not be made to the document; instead, the document should be cancelled and a new one completed. In these situations, the healthcare professional with overall clinical responsibility, or nominated deputy, should countersign the document within:

- 24 hours (if in a hospital)
- 48 hours (if in a hospice)
- 72 hours (if in the community)

**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 (please refer to the '**transferring**' section below for information relating to transferability of the ReSPECT document).

Within the healthcare setting where a person is receiving care the ReSPECT document stored in the person's current health record should be the same as the version held by the person. **Therefore, this version can be regarded as the authoritative record of the person's recommended plan for emergency care and potentially life-sustaining treatment, including CPR, unless it conflicts with a person-held copy which has been completed subsequently.**

**It is therefore essential that the ReSPECT document is reviewed with appropriate frequency 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 who 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 will include communication with GP and nursing services, including out-of-hours providers, ambulance services and palliative care services. It may also include sharing via shared electronic patient records, where these are in use. All sharing of a person's ReSPECT information should be documented clearly.

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

### *Validity of a person's ReSPECT document*

The ReSPECT document does not constitute a legally binding consent to or refusal of care or treatment. It should be used as a guide to best-interests decision-making by healthcare professionals in an emergency setting, in relation to emergency care, including potentially life-sustaining treatments. As such, it constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an ADRT (please refer to the **glossary** for further information).

A person's ReSPECT document will remain valid as an up-to-date plan for emergency care and potentially life-sustaining treatment until it is cancelled, or unless the decision-maker at the time has reasonable doubt that the document is not valid, or not applicable to the current situation. The decision-maker should bear in mind that they should have good reason for and be prepared to justify a decision to go against an existing ReSPECT document that is valid and applicable.

Please note that the ReSPECT process and document are not solely aimed at decisions about limiting treatment; the process is intended to support people to articulate and share their views about treatments and approaches to care that they *do* want, as well as about those that they don't. The process and document can cover recommendations about both specific treatments (such as clinically-assisted nutrition) and approaches to care (such as whether a person would want to be taken to hospital in an emergency).

**A healthcare professional has no legal duty to give a person a treatment that they judge to have no reasonable chance of success, or to be clinically inappropriate, including CPR.**

### *Review of a person's ReSPECT document*

The ReSPECT document should be reviewed:

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

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

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

***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. The healthcare professional with overall clinical responsibility should ensure that a clear plan for review with appropriate frequency is set out in the person's health record and that that plan is implemented. If a ReSPECT document is completed for a person who is dying from an advanced and irreversible condition, frequent review may not be needed unless the ReSPECT document contains recommendations for treatment that may not be wanted as the person's condition progresses further. A person who has a ReSPECT document but who has no pressing healthcare needs may not receive routine healthcare reviews, especially in the community. In that situation, it is recommended that the ReSPECT document is 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.

***Review if a person's clinical condition changes substantially***

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

***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 and defer review until after their arrival.

In the case of a child, review of the documentation prior to routine hospice admission for respite care, with no change in health status, is not required. In this situation, the document should be reviewed in the hospice setting as part of their admission assessment.

It is the responsibility of the clinical team in the receiving care setting to review the ReSPECT document with the person as soon as is reasonably practicable following their arrival, so as to inform

the ongoing care of the person. It is the duty of the healthcare professional with overall clinical responsibility for a person to ensure that such review takes place, and to countersign the document within the timescales specified below.

Formal review of the recommendations on a ReSPECT document should take place whenever a person transfers between healthcare settings, within the following **maximum timescales**, for the document to retain validity:

For adults

- Transfer from hospital/ to home/ care home- **within one week**
- Transfer from hospice to home/care home – **within one week**
- Transfer from home/ care home to hospital- **within 24 hours**
- Transfer from home/ care home to a hospice- **within 48 hours**
- Transfer between different hospitals or hospital teams or units- **within 24 hours**
- Transfer between sites in the same healthcare setting (e.g. home to care home) with **no change in healthcare professional - review needed if change in clinical condition.**
- Transfer between sites in the community with **a change in healthcare professional** (e.g. home to care home, with a change in GP)- **within one week**
- **Transfer from residential school/college to home – review annually in each setting AND if any clinical changes**

For young people under 18 years of age

- Transfer from hospital/ to home/ care home- **within one week** unless there has been no change in their clinical condition and the responsible clinician at the hospital believes the document to be current and in keeping with expressed views of the parents/persons with PR and, where applicable, the child/young person . A review should take place, however, if they have not previously held a ReSPECT document in the community, or if there have been any changes to documentation during admission
- Transfer from hospice to home/care home – **within one week** unless a hospice admission was for respite, there has been no change in the child's clinical condition AND nursing or medical staff at the hospice believe the document to be current and in keeping with expressed views of the parents/persons with PR and, where applicable, the child/young person)
- Transfer from home/ care home to hospital- **within 24 hours**
- Transfer from home/ care home to a hospice- **within 48 hours** unless the admission is for respite, there has been no change in the child's clinical condition AND nursing or medical staff at the hospice believe the document to be current and in keeping with expressed views of the parents/persons with PR and, where applicable, the child/young person
- Transfer between different hospitals or hospital teams or units- **within 24 hours**
- Transfer between sites in the same healthcare setting (e.g. home to care home) with **no change in healthcare professional - review needed if change in clinical condition.**

- Transfer between sites in the community with a **change in healthcare professional** (e.g. home to care home, with a change in GP)- **within one week**
- **Transfer from residential school/college to home – review annually in each setting AND if any clinical changes**

These maximum timescales are only intended to apply to transfers of care where there is no immediate, emergency healthcare issue. In an emergency, and when decisions about potentially life-sustaining treatments must be taken, the ReSPECT document will be a valuable guide to decision-making.

As stated above, it is important for the healthcare team that has been caring for a person to review their ReSPECT document immediately prior to a change in healthcare setting (for example, just before discharge from a hospital or hospice) to check that the recommendations on their ReSPECT document remain appropriate and that the ReSPECT document travels with them to the new setting.

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 with/for them. This will be a matter of clinical judgement for the healthcare professional with overall clinical responsibility for a person, and other members of the healthcare team. It is important to ensure that patients and those important to them understand that the document applies in the new healthcare setting.

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

### ***Review if the person or their representative requests it***

A person who has mental capacity to consider and discuss the relevant decisions, or (in the case of a child/young person) person(s) with PR, and/or the child/young person 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 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 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**

### *Amending or cancelling a person's ReSPECT document*

A ReSPECT document should be cancelled when its contents are no longer valid, or no longer applicable. For example, this may be because the person's clinical condition has changed, because they have requested cancellation, or because of a change in the assessment of the best interests of a person who lacks capacity.

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

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

Amendments should not be made to a person's ReSPECT document; if a change is needed to any of the recommendations or information contained on a ReSPECT document, it should be cancelled as above and a new ReSPECT document completed. When any amendment is considered, this should be done with careful adherence to the principles of shared decision-making, good clinical practice and capacity legislation. Please be aware that the presence of amendments may prevent a decision-maker from using the contents of a ReSPECT document confidently in an emergency setting.

## **9. 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. Please see above for timescales for review of the ReSPECT document when people move between healthcare settings.

### *Sharing the ReSPECT document across healthcare settings*

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

It is essential that the person, and with his/her agreement, their family and/or other carers who have been involved in the process of completing the ReSPECT document, or those holding PR for a child, understand its content and are empowered to show it to the healthcare team without delay in any emergency or in any new setting. They (or their representative if they do not have capacity) should also be involved in conversations about sharing the recommendations contained in the document across health and care settings.

However, the ultimate responsibility for sharing the contents of the ReSPECT document, even if not the document itself, lies with the healthcare professional with overall clinical responsibility, in any given setting. Particular care should be taken if information must be shared urgently, and consideration given to the most appropriate means of sharing of urgent information (e.g. by email, fax, or telephone), in line with local procedures and national guidance [ref: PRSB guidance on safe use of email in health and care].

A person's ReSPECT document, including the recommendation about CPR, should 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.

Where a person has a shared electronic patient record, an alert should be set up on this record indicating the existence of the ReSPECT document and including reference to the recommendation about CPR. Detail of the recommendations contained within the ReSPECT document should also be included in the electronic record and kept up-to-date.

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.



### *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 him/her, and/or the person(s) with PR in the case of a child/young person are aware of the document, its meaning, and its contents, unless there is good reason for this not to take place (for example, if the person has indicated that they do not wish to know, 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).

Robust reasons for any lack of discussion should be documented clearly in the person's current health record. Under such circumstances, and only in the case of adults, 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 letter). 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.

For those aged under 18 years, reasons for any lack of discussion with the young person should be documented clearly in their current health record. The parent(s)/person(s) with PR, who will have been part of the best-interests decision-making process, should be given the ReSPECT document so that it is available to guide clinical care when needed. They may choose to keep this with the child (e.g. in their school bag) or carry it themselves. Those caring for the child/young person should be aware of where this document can be found.

The ReSPECT document that accompanies the person on discharge should be the most recent, original, 'active' version. The document should not be photocopied for clinical use, but may be photocopied for audit or administrative purposes; in this case copies must be crossed through with 2 diagonal lines in black ink and the words "COPY ONLY – NOT FOR CLINICAL USE" should be written clearly between them. A copy should be retained as part of the person's current health record in that setting, and must be crossed through with 2 diagonal lines in black ink and the words "COPY ONLY – NOT FOR CLINICAL USE" should be written clearly between them.

## **10. Training**

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

Healthcare provider organisations should consider how they plan to link training in effective communication and the use of the ReSPECT process into existing training for their clinical staff. All healthcare staff should be trained and supported to enable safe and effective use of the ReSPECT



document, and participation in this training should be recorded locally and subject to continuous audit. Familiarisation with the ReSPECT process, and documentation should also form part of staff mandatory resuscitation training.

### **11. Monitoring compliance and effectiveness**

It is expected that this section will be tailored towards local use. It may be possible to combine monitoring of use of the ReSPECT document with ongoing local DNACPR audits. Suggestions are included below:

Element to be monitored	(1) All organisational incidents involving the ReSPECT process (2) ReSPECT document completion/decision-making (regular current inpatient notes review).
Lead	(1) Resuscitation Lead (2) Resuscitation Lead
Tool	(1) Datix /alternative incident reporting system. (2) Review of current health records and ReSPECT documents.
Frequency	(1) As and when alerts occur. (2) Monthly.
Reporting arrangements	Via reports to the resuscitation committee/ Clinical governance committee/ Trust board.
Acting on recommendations	To be determined locally
Change in practice and lessons to be shared	To include mandatory resuscitation training and other local means for dissemination

### **12. Acknowledgements**

This policy was produced and reviewed by the members of the London End of life Care (EOLC) documentation project delivery group.

We are grateful to the Royal Cornwall Hospitals NHS Trust on whose work this policy is based.

### **13. Equality and Diversity**

It is expected that each healthcare provider will conduct its own equality impact assessment.

#### **Equality Impact Assessment**

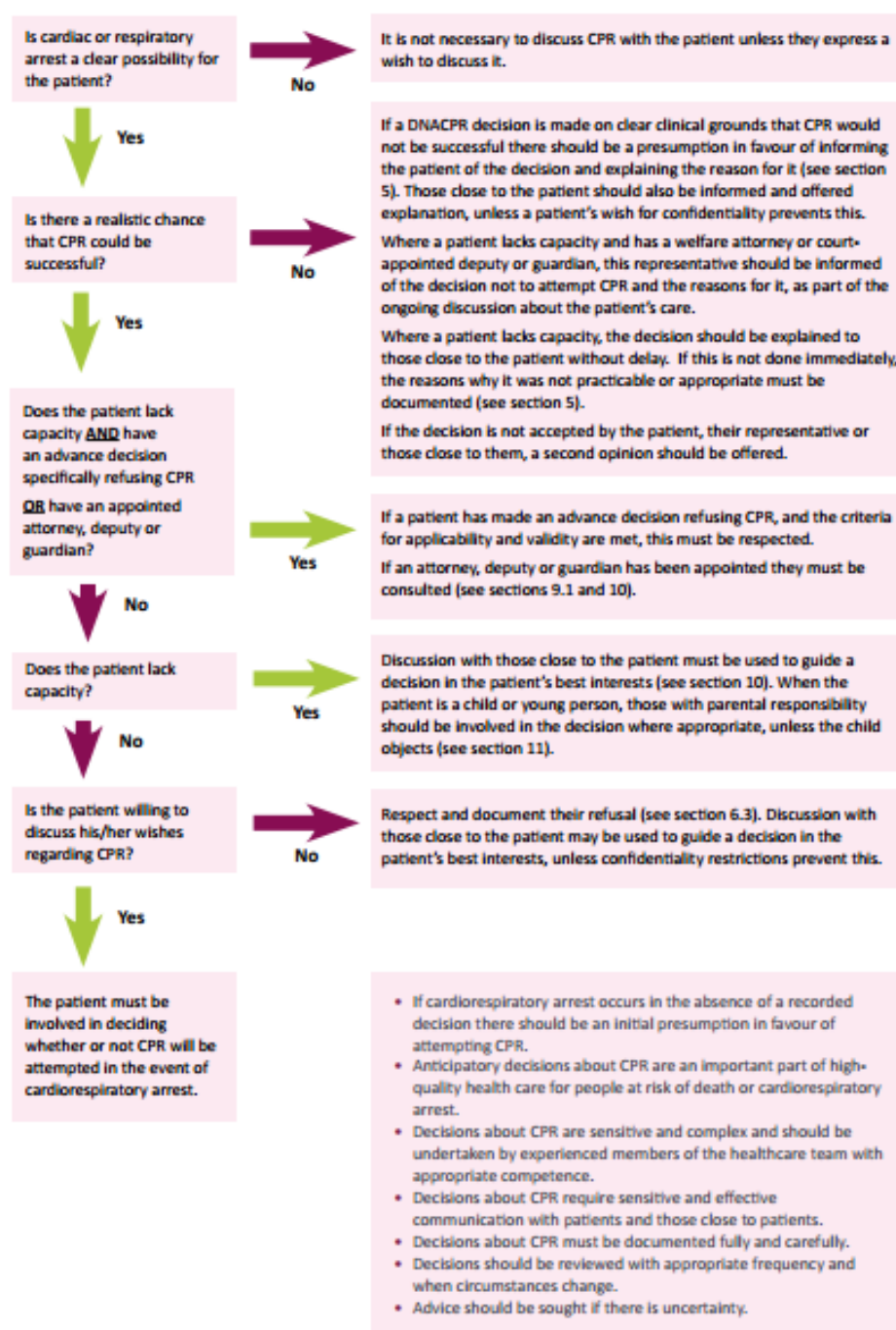
The Initial Equality Impact Assessment Screening form is at Appendix 5.

#### **Appendix 1: The ReSPECT document**

ReSPECT London Policy

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

***Appendix 3: Decision Making Framework for recommendations about CPR***



Taken from 'Decisions relating to cardiopulmonary resuscitation', 3rd Edition (1<sup>st</sup> revision) 2016. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.

#### Appendix 4: Individual Healthcare Provider Governance Information

Title	
Date Issued/Approved	
Date Valid from	
Date Valid to	
Directorate / Department responsible (author/owner)	
Contact details	
Brief summary of contents	
Suggested Keywords	
Target Audience	
Executive Director responsible for Policy	
Date revised	
This replaces (exact title of previous version)	
Approval route (names of committees) /consultation	
Divisional Manager confirming approval processes	
Name and Post Title of additional signatories	
Signature of Executive Director giving approval	
Publication Location (refer to Policy on Policies – Approvals and Ratification)	
Library Folder/Sub Folder	
Links to key external standards	
Related s	
Training Need Identified?	

#### Version control table

Date	Version No	Summary of Changes	Changes made by (Name and job title)


*Appendix 5: Initial Equality Impact Assessment Form*