Recommended Summary Plan for Emergency Care and Treatment

Policy for use across all providers in Lincolnshire

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1. Introduction

The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, then that treatment is no longer justified (BMA, RC (UK) RCN 2007). Also, even potentially life-saving treatment can be withheld or withdrawn if it is not in the patient's best interests and the patient lacks capacity to make that decision for themselves at that time.

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 in their situation.

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

1.1 What is ReSPECT?

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest, but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

1.2 How does it work?

The plan is created through conversations between a person and one or more of the health professionals who are involved with their care. In the case of a child or young person the conversation is held with the person with parental responsibility, and/or where appropriate the young person themselves.

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

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 doctors, 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 agreed clinical recommendations on a ReSPECT form.

1.3 What is a ReSPECT conversation?

A ReSPECT conversation follows the ReSPECT process by:

1. Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future
2. Identifying the person's preferences for and goals of care in the event of a future emergency
3. Using that 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
4. Making and recording shared decisions about specific types of care and realistic treatment that they would want considered, or that they would not want, and explaining sensitively advance decisions about treatments that clearly would not work in their situation
5. Making and recording a shared decision about whether or not CPR is recommended

1.4 Cardiopulmonary resuscitation

Survival following cardiopulmonary resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Whilst patients who have an acute event, such as a myocardial infarction, may recover with CPR, the chances of survival are much lower for patients who have a cardiopulmonary arrest due to progression of a life limiting condition. 80% of cardiac arrests occur outside hospital and 90% of these will result in death. When cardiac arrest occurs in hospital, 13-17% survive to hospital discharge and many of these will have long term disability.

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. It is essential to identify patients for whom cardiopulmonary arrest represents the terminal event in their illness, and for whom CPR is therefore inappropriate.

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 if death occurs there is no added loss of dignity. It is also essential to identify those patients who would not want such treatments to be attempted in the event of a deterioration in their condition and who competently refuse these treatment options.

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.

1.5 Glossary

Advance Care Plan (ACP)
An Advance Care Plan is a structured documented discussion with patients 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 patient'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 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 patients and 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.

2. General principles

2.1 This policy is intended for anyone, but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons. The policy applies to children and young people as well as adults, in all care settings across Lincolnshire.

2.2 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, admission to ICU for intubation and ventilator support, inotropic and other cardiovascular support, as well as CPR.

2.3 This policy applies to all of the multidisciplinary healthcare team involved in the patient's care.

2.4 Variations in local policies can cause misunderstandings and lead to distressing incidents for patients, families and staff. Increased movement of patients and staff between different care settings makes a single, integrated and consistent approach to this complex and sensitive area a necessity. Therefore, agreement has been reached across providers to use a single ReSPECT form and policy.

2.5 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.

2.6 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 patients. However, they may still wish to discuss other aspects of emergency care and treatment, so then a ReSPECT conversation may be appropriate.

2.7 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.

2.8 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. These decisions should never be dictated by 'blanket' policies.

2.9 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, they should not be attempted.

2.10 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 patient or of those close to the patient. However, there is a presumption in favour of informing a patient of such decisions. The patient and those close to the patient 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.

2.11 For a person in whom CPR or other life-sustaining treatment may be successful, when a decision about future treatment is being considered there should be a presumption in favour of involvement of the person in the decision-making process.

2.12 If a patient with capacity refuses CPR and other life sustaining treatment, or a patient lacking capacity has a valid and applicable Advance Decision Refusing Treatment (ADRT), specifically refusing a particular treatment, this must be respected.

2.13 If a patient lacks capacity then decisions should be made following the "best interests" process as per the Mental Capacity Act 2005. Those close to the patient must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a best interests decision, if it is practicable and appropriate to consult them. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision-makers.

2.14 In the case of a child or young person under 18 it is necessary to consider their age and level of maturity regarding their ability to make decisions for themselves (Gillick competence). Those aged 16 or 17 are assumed to have capacity to make their own decisions unless shown otherwise through a capacity assessment. Normally parents or people with parental responsibility would be included in all such conversations, providing the patient agrees to this. It would be essential to include parent(s) or the people with parental responsibility in the decision-making for those who lack such competence.

2.15 If the child or young person is over 16 or is felt to be competent to make their own decisions, and they wish their health information to be kept confidential from their parents, it should be noted that the Department of Health Code of Practice on Confidentiality (2003) provides that:

> "The principle of confidentiality can be breached if a competent young person or child is refusing treatment for a life threatening condition. The duty of care would require confidentiality to be breached to the extent of informing those with parental responsibility for the child who might then be able to provide the necessary consent to the treatment"

This should be considered as being about sharing information with the parents to enable an application to be made to court to resolve any dispute.

2.16 There should be clear, accurate and honest communication with the patient and (with the patient's permission) those close to them, including provision of information and checking of their understanding about what has been explained to them.

2.17 For a patient who lacks capacity to decide about confidentiality, there should also be a best interests decision made regarding to who to involve in the decision-making process and what information should appropriately be shared to enable this, as per the MCA.

2.18 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.

2.19 Any decision about CPR and other life-sustaining treatment should be communicated clearly to all those involved in the patient's care.

2.20 Each decision about CPR and other life-sustaining treatment should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of these decisions (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of these decisions.

2.21 Where a patient or those close to a patient disagree with a DNACPR decision or a decision to withhold other life-sustaining treatment, a second opinion should be offered. Endorsement of the decisions by all members of a multidisciplinary team may avoid the need to offer a further opinion.

2.22 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.

2.23 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. Examples may include choking, a displaced tracheal tube or a blocked tracheostomy tube, anaphylaxis, and other unforeseen and potentially reversible causes.

2.24 ReSPECT forms are not legally binding. The ReSPECT form should be regarded as an advance clinical assessment and recommendations, recorded to guide immediate clinical decision-making in the event of a patient'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 or not to attempt CPR or other life-sustaining treatment rests with the healthcare professionals responsible for the patient's immediate care.

2.25 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. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable) a carefully considered decision not to start inappropriate CPR or other life-sustaining treatment should be supported.

2.26 Failure to make timely and appropriate decisions about life-sustaining treatment will 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 unacceptable, especially when many would not have wanted such treatment had their needs and wishes been explored.

2.27 The original ReSPECT form must accompany a patient when they move from one setting to another.

3 Organisations that agree to the principles of this policy

- BMI The Lincoln Hospital
- East Midlands Ambulance Service
- Lincolnshire Care Association (LinCA)
- Lincolnshire County Council
- Lincolnshire Community Health Services
- Lincolnshire East CCG
- Lincolnshire Medical Committee
- Lincolnshire Partnership NHS Foundation Trust
- Lincolnshire West CCG
- LIVES
- Marie Curie
- South Lincolnshire CCG
- South West Lincolnshire CCG
- St Barnabas Lincolnshire Hospice
- Thames Ambulance Service
- United Lincolnshire Hospitals NHS Trust

4. Legislation and guidance

4.1 Legislation

Under the Mental Capacity Act (2005) clinicians are expected to understand how the Act works in practice and the implications for each patient for whom emergency care and treatment decisions, including DNACPR, have been made.

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

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14)

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.

Where patients are detained under the Mental Health Act, the provisions of this act only apply to decisions about psychiatric treatment for a psychiatric 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.

4.2 Guidance

Guidance has been developed by the Resuscitation Council (UK):

- Recommending standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
- Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (October 2007, updated October 2014)

Decisions relating to Cardiopulmonary Resuscitation is available at https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/.
Further information about ReSPECT is available at https://www.respectprocess.org.uk/

5. Procedure

5.1 For the majority of people receiving care in a hospital or community setting, the likelihood of sudden deterioration and cardiopulmonary arrest is small; therefore, no discussion of such an event routinely occurs unless raised by the individual.

5.2 In the event of an unexpected cardiac arrest every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council (UK) unless a valid DNACPR decision or an ADRT is in place and made known. If the person suffering the cardiopulmonary arrest is unknown to the person attending them, and/or the existence or otherwise of a ReSPECT form or other relevant documentation is unknown, then CPR should be commenced immediately. It would not be appropriate to delay CPR in order to identify the person or look for documentation regarding their wishes. Positive identification of the person and the discovery of documentation regarding their wishes during CPR attempts may inform a decision whether to continue or cease those attempts.

5.3 In the event of a clinician finding a person dead and where there is no DNACPR decision or an ADRT to refuse CPR, the clinician must rapidly assess the case as to whether it is appropriate to commence CPR. Providing the clinician has demonstrated a rational process in decision making, the employing organisation will support the member of staff if this decision is challenged. Professional judgement must be exercised and documented as soon as practically possible after the event. Consideration of the following will help to form a decision:

- What is the likely expected outcome of undertaking CPR? *For example, it would be inappropriate to start CPR if it will not re-start the heart and maintain breathing.*
- What is the balance between the right to life and the right to be free from inhuman and degrading treatment (European Convention on Human Rights)?

5.4 It is rarely appropriate to discuss DNACPR decisions in isolation from other aspects of end of life care. DNACPR is only one small aspect of advance care planning which can help patients achieve their wishes for their end of life care. The ReSPECT form and process seek to address this by encouraging better communication and shared decision-making. The patient should be given as much information as they wish about their situation, including information about CPR in the context of their own illness and sensitive communication around dying and end of life issues.

5.5 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 1) should be used and accepted by all providers across Lincolnshire.

5.6 It is possible that a patient 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 patient's responsible senior clinician.

5.7 Similarly, a photocopy of a ReSPECT or DNACPR form should be accepted unless there is evidence it should not be considered valid. However, if the original form is not present with the patient, reasonable steps should be taken to ensure a new form is completed at the earliest opportunity.

5.8 It is up to individual organisations to decide who they deem to be suitably qualified to complete a ReSPECT form with a patient or their family. The recommendation from the ReSPECT Implementation Group is that this should not be restricted to certain staff groups or grades, but that any member of clinical staff who has undergone appropriate training should be permitted to have a ReSPECT conversation and complete the form if they feel able to do so.

5.9 The healthcare professional completing the ReSPECT form should fill in their details and sign the form. The decision must be discussed and agreed with the senior clinician responsible for the patient's care. This might be their GP, hospital consultant or out of hours practitioner depending on the setting. The name of the responsible senior clinician the ReSPECT decisions were discussed with should be clearly documented and their agreement confirmed.

5.10 Guidance for clinicians on how to complete the various sections of a ReSPECT form can be found in Appendix 2. Further information for patients, 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/.

5.11 For patients who are being cared for within United Lincolnshire Hospitals NHS Trust, there is a requirement for the responsible consultant to review and endorse the form within 24 hours of the decision being implemented. They must countersign the form in the space provided. There is not a similar requirement for GPs given the logistical difficulties this might present for patients in the community, but where appropriate the GP may wish to countersign the form to further confirm their agreement with the decision.

6. Situations where there is a lack of agreement

6.1 A person with mental capacity may refuse any treatment from a doctor or nurse 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.

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

6.3 A previous verbal request to decline CPR or other life-sustaining treatment should be taken into account when making a best interest decision once a patient 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 be documented in the patient's case notes by the person who it is directed to and any decision to take actions contrary to it must be robust, accounted for and documented clearly in the notes.

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

6.5 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. The possibility of application to court exists as a last resort to resolve disputes and legal advice should be obtained with that in mind.

7. Cancellation of emergency care and treatment decisions

7.1 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 ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional, who will print their name and GMC number clearly underneath their signature for purposes of validation.

7.2 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 patient.

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

8. Temporary suspension of emergency care and treatment decisions

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

8.2 Pre-planned: Some procedures could precipitate a deterioration or cardiopulmonary arrest, for example induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. 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 patient and/or carer, if appropriate, will need to take place.

8.3 Acute: 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.

8.4 After the event, the ReSPECT decisions should be reviewed and discussed with the patient and reinstated where appropriate.

References

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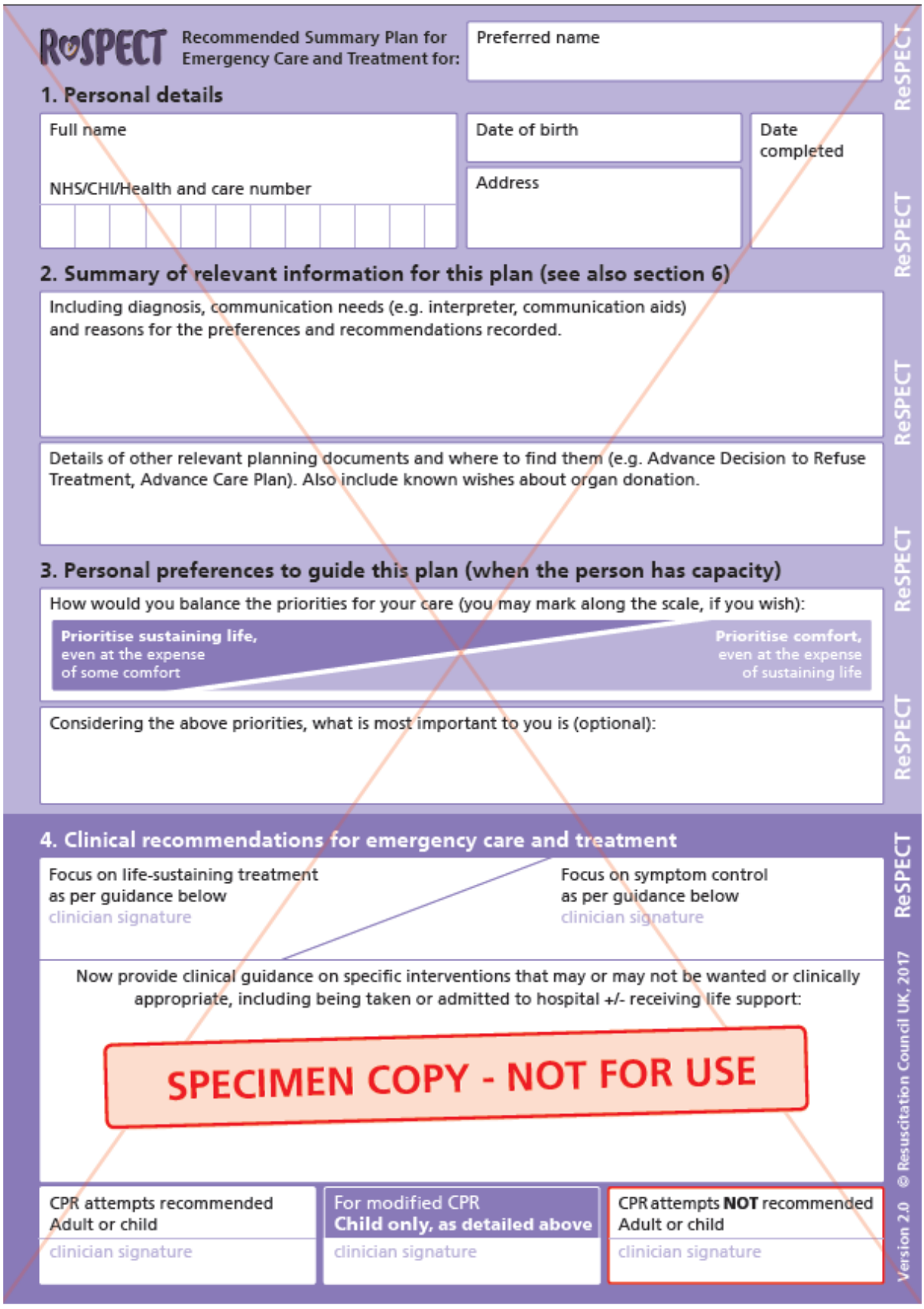
- British Medical Association, (2001). Withholding or withdrawing life-prolonging medical treatment. 2nd ed. London, BMA Books.
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland 2010.
- GMC Treatment and Care Towards the end of life: good practice in decision 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/.
- 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 - ReSPECT form



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

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

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

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

ReSPECT

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5. Capacity and representation at time of completion

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

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

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 making this plan.
- ☐ **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
- ☐ **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old 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.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time

Senior responsible clinician

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend/other			
GP			
Lead Consultant			

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

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

Appendix 2 – Quick guide for clinicians

How to complete a ReSPECT form: Quick guide for clinicians

The numbers relate to the section numbers on the ReSPECT form. **Version 1.0**

1. Personal details

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

Preferred name

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

2. Summary of relevant information for this plan

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

A. Insert a brief summary of the background to the recommendations in section 4 (e.g. diagnosis, previous and present condition, prognosis, communication difficulties and how to overcome them);
B. Record specific detail and the location of documents such as advance statements, Advance Decisions to Refuse Treatment, advance care plans, organ donor cards.

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

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

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

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

4. Clinical recommendations for emergency care and treatment

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

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

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

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan?
Consider and answer this question for all adults. If there is any reason to suspect impaired capacity perform a formal assessment of capacity and document it fully in the person's health records.

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations?
Consider and answer this question for adults and children. When the answer is 'yes' insert details in section 8.

6. Involvement in making this plan

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

If this plan is being completed without involving the patient...
If there has been no shared decision-making with the person themselves (or no involvement of family or other representatives of a person who does not have capacity to be involved) use the red-bordered box to summarise the reasons for this. Make sure that the reasons are detailed fully in the clinical record, together with a clearly defined plan to involve the person or their representatives as soon as this is possible or appropriate.

7. Clinicians' signatures

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

8. Emergency contacts

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

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

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

Appendix 3 – Decision-making framework for CPR