Guideline

ReSPECT – Recommended summary plan for emergency care and treatment: Information for patients, relatives and staff

Key messages:
- ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices.
- ReSPECT provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.
- ReSPECT is a process involving an individual, health professionals, family and care givers in a discussion about priorities for care and treatment.
- ReSPECT uses standardised documentation to record an individual’s personal priorities for care and agreed clinical recommendations for treatment and care.
- ReSPECT includes a recommendation as to whether cardiopulmonary resuscitation (CPR) should be attempted in the event of a cardiac arrest.
- ReSPECT is for anyone but will have particular relevance to people with complex health needs, those nearing end of life or those at risk of sudden deterioration.
- ReSPECT does not replace more detailed treatment plans or advance care planning but provides a summary for immediate access in an emergency.
- ReSPECT is a national initiative and has been designed to be used across healthcare settings, throughout the UK. For more information https://www.respectprocess.org.uk/
- ReSPECT will replace the universal form of treatment options (UFTO) at CUH.
- Where needed or desired, patients will be discharged with a ReSPECT form instead of an East of England DNACPR form.

1 Scope

Trust-wide (excluding day case and obstetric admissions)
2 Purpose

ReSPECT has been developed to improve patient and family involvement in decision making. ReSPECT allows consideration of CPR decisions in the context of broader care and treatment and records decisions on a standardised form. Discussions enable the formulation of a personalised summary of recommendations for an individual’s clinical care in a future emergency in which they are unable to make or express choices.

The ReSPECT process is designed to:

- Encourage the discussion and documentation of recommendations for an individual’s clinical care, including a decision about CPR.
- Encourage forward planning, consideration of recommendations ahead of any emergency in which individuals are unable to make or express choices.
- Improve communication between medical and nursing staff, as well as between staff, patients, family members and care givers, and across different health care settings.
- Ensure that patients get appropriate treatments.

3 Background

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

ReSPECT has been developed by a Working Group comprising of more than 30 representatives of the public and professional organisations from a range of care settings and clinical specialties as well as the regulatory body the Care Quality Commission (CQC). Full information about the process and the organisations which support it can be found at https://www.respectprocess.org.uk/.
4 Who should have a ReSPECT form?

This ReSPECT process can be for anyone, but is especially relevant for people:

- with particular health needs that may result in a sudden deterioration in their health
- with a life-limiting condition, such as advanced organ failure, advanced cancer or frailty
- at risk of sudden events, such as epilepsy or diabetic crisis
- at foreseeable risk of death or sudden cardiorespiratory arrest
- who want to complete the ReSPECT process and documentation for other reasons.

On admission to hospital consideration should be given to whether a patient would benefit from involvement in the ReSPECT process. All patients (excluding obstetric admissions or those admitted as day cases) can have a ReSPECT form completed.

A patient information leaflet is available on Connect which can be given to patients either on admission or prior to admission for elective surgery (http://connect2/respect), or in outpatients for patients with chronic conditions.

5 Who should be involved in decision making

Before completing the ReSPECT process you will need to assess the patient’s capacity to be involved in making these recommendations.

Further information on assessing capacity can be found in the following policies, available via the following link: http://merlin/Pages/Results.aspx?k=Mental%20Capacity

5.1 Patients with capacity

If the person has capacity to take part in the making of the ReSPECT recommendations, they must be involved fully with the process. There is a legal requirement to involve patients with capacity in discussion regarding CPR recommendations unless you feel that to do so would cause physical or psychological harm.

Many people want to have the support of family, friends or carers in the discussion, and some may choose to have a family member or friend advise them on what choices to make.

If they don’t want their family or other carers to know about their condition or their choices, they should make sure that the healthcare team knows about this so that their wishes for confidentiality can be respected.
5.2 Patients lacking capacity

If the patient lacks capacity then decisions regarding their treatment should be made according to the best interest principles of the Mental Capacity Act (2005).

Where the person does not have capacity to take part in the making of the recommendations, and if there is no legal proxy to represent the person (a person with Lasting Power of Attorney for Health and Welfare) the clinical team must consult family or friends about a person’s situation and previously expressed views or wishes, in order to make recommendations that are in that person’s best interests. However, the responsibility for making those recommendations rests with the senior responsible clinician. The family should not be given the impression that they are being asked to make them.

A patient who is confirmed as lacking capacity may have a designated decision maker acting on his or her behalf under a Lasting Power of Attorney (LPA) for health and welfare decisions. The LPA must have been legally registered at the Office of the Public Guardian, with the relevant section completed authorising the attorney to make a decision in this particular situation. Attorneys are not able to demand treatment that is clinically inappropriate, but where a treatment, such as CPR, may be successful and a decision is based on the balance of benefits and burdens, their views about a patient’s likely wishes must be sought.

If there is disagreement between the healthcare team and appointed attorney, and this cannot be resolved through discussion and a second clinical opinion, legal advice must be sought.

In the event of a patient lacking capacity, with no LPA in place, and nobody other than hospital staff or paid carers are able to participate in the decision making process, there may be a duty under the Mental Capacity Act to refer to an independent mental capacity advocate (IMCA), particularly if there is disagreement among the clinical team. The IMCA will investigate the circumstances to ensure that any decision is in the best interests of the patient.

The clinician is obliged to take the IMCA’s submissions into account, but ultimately is responsible for the final decision.

http://connect2/article/1811/Mental-Capacity

http://connect2/article/1812/The-Independent-Mental-Capacity-Advocacy-service-IMCA-

5.3 Decisions about children and young people

Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving the child, his/ her parents or guardians and the healthcare team. The team should involve the child to the extent that is appropriate for the individual circumstance.

If there is disagreement between the recommendations of the clinical team and the wishes of the parents and/or a child who is competent, every effort should be
made to resolve this through discussion, explanation and a second opinion. If disagreement persists, the courts may be asked to make a decision.

Further information on when a child is considered legally competent to make decisions regarding their treatment can be found in the following policy:


6 When will ReSPECT be completed?

ReSPECT documentation will form part of the admission and ward round workflows in EPIC (the hospital’s electronic patient record). It can also be completed in outpatients.

Please see appendix 1 for a copy of the flowchart outlining the EPIC workflow.

If an in-patient would benefit from ReSPECT the form should be completed the first time the patient is seen on the post-take ward round, but certainly no later than 72 hours after admission. It can also be completed in outpatients, for example for those with chronic or deteriorating conditions, or prior to admission for elective surgery.

A ‘Best-Practice Advisory’ (BPA) will be triggered 24 hours after admission for all patients over 18 years or age (excluding obstetric and day case admissions) directing doctors to complete the ReSPECT process.

When the ReSPECT form is opened in the patient chart the doctor will be prompted to select one of the three options (see the screenshot below).

If the doctor does not think the patient would benefit from undertaking the ReSPECT process, option 1 is selected. In doing this, the doctor is confirming...
that ‘A ReSPECT conversation is not needed at this time: I have confirmed that
the patient wishes to be considered for all treatment including attempted CPR’.

Many patients without comorbidities might be surprised about being asked about
CPR and other treatments, and so we suggest that doctors say something like:
“There are lots of treatments available in hospital. We routinely check with all
patients whether or not they would like to be considered for all treatments,
including resuscitation. “Checking in this way will de-stigmatise the conversation,
and allow some patients who do not want attempted CPR (or other treatments)
but are too frightened to bring it up themselves, to express their wishes.

If the doctor feels that the patient would benefit from or like to have a ReSPECT
conversation, option 2 is selected. All mandatory fields of the form should then
be completed (the procedure for completing the form is described later in this
guidance in section 7).

If the patient has previously had a ReSPECT conversation and form completed,
then option 3 is selected. (If you are not sure if one has been completed before,
you can click on the ‘resuscitation banner’ or go to ‘patient summary extracts’).
In this case the previously completed form will load automatically. This should
be reviewed and updated as appropriate (the procedure for review is also
described in section 7).

Anyone involved in the care of the patient may initiate a conversation about
ReSPECT, if they feel competent to do so. In general we would expect this to be
a doctor of ST3 level or above. ReSPECT discussions should take place as
soon as practically convenient and with consideration given to any suspicion that
clinical deterioration may take place, to enable as far as possible, the patient to
be involved in the discussions.

The ReSPECT process involves a conversation which:

- develops a shared understanding of a person’s condition, circumstances
  and future outlook
- then explores any outcomes that the person values or fears – for
  example someone might fear losing their mental faculties, while for
  others the ability to be outdoors might be important.
- the process then goes on to make and record agreed clinical
  recommendations for their care and treatment in a future emergency in
  which they cannot make or express decisions at the time. These clinical
  recommendations are made to try to ensure that the outcomes which
  patients value are maintained, while those that they do not want or fear
  are avoided.
7 Who should complete the form?

The ReSPECT documentation should be completed by a doctor looking after the patient.

Any doctor competent to do so can complete the documentation (following a conversation with the patient or, if you have assessed that the patient does not have capacity to participate in this discussion, those close to them).

It is good practice for this to be done by the senior responsible clinician (for example the consultant on the post take ward round). If ReSPECT recommendations are completed on EPIC under a junior doctor’s sign-in (e.g. during a ward round), the name of the consultant responsible for the decision should be clearly documented.

Where the ReSEPCT conversation has been undertaken by a more junior doctor, decisions must be discussed with the consultant responsible for the patients care at the earliest opportunity; their name should be put into the section ‘senior responsible clinician’, with details of the discussion documented in the notes.

It is good practice for a consultant to review decisions and to document this review.

All staff are responsible for ensuring they are familiar with this guidance and comply with it in their practice; escalating to medical staff when ReSPECT has not been completed within 72 hours or has not been correctly documented.

Clinical staff are responsible for ensuring they are aware of the plan of care for all patients under their care, in particular the patient’s CPR status, so that they respond appropriately in the event of an emergency situation.
8 How is the form completed in EPIC?

The process for completing the SMART form in EPIC is described below. There is a flowchart summarising this process in appendix 1 at the end of this guideline. More details can be found in the EPIC ‘Quick start’ guide available on Connect (http://connect2/respect) or by clicking on the Education Library tab in EPIC. Guidance is also given in dialogue boxes on the SMART form.

The ReSPECT form appears in the admission and ward round navigators (see screenshot below). You can also access it by clicking on the resus status in the patient header.
A ‘Best-Practice Advisory’ (BPA) will be triggered 24 hours after admission for all ADULT patients (over 18yrs) directing doctors to complete the ReSPECT process. You can use the hyperlink to access the form.

If you need to complete a ReSPECT form as an outpatient there will be a ReSPECT assessment activity down the left hand side of the screen in the patients chart.

The form will then be completed exactly the same way as you would as an inpatient; however an order will not need to be placed as this is for inpatient encounters only.

The ReSPECT orders section shows any resus status or orders previously placed.
When the form is opened, you will be prompted to select one of three options.

**Option 1** - A ReSPECT conversation is not needed at this time: I have confirmed that this patient wishes to be considered for all treatments, including attempted CPR.

If this option is selected the mandatory banner in the form will turn green showing that all mandatory fields are complete.

The doctor must now complete the ReSPECT order. The order will be ‘For Active Treatment, Attempt CPR’. The patients chart cannot be closed until the order is complete.

**Option 2** - This patient would benefit from or like to have a ReSPECT conversation.
If this option is selected then section 1-7 of the form are visible. **Sections 4, 5, 6, 7 are mandatory. The mandatory banner will not turn green until all mandatory sections are completed.**

Below is guidance on how to complete each section of the ReSPECT form in EPIC. This information can also be accessed in the EPIC smart form by clicking on the information icons in each field.

**Section 1: 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.

**Section 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 (including Lasting Power of Attorney, if one has been appointed).

A. Insert a brief summary of the background (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.

**Section 3: Personal preferences to guide this plan (when the person has capacity)**
Ask the person to describe their priorities for their care. The scale on the SMART form (see screenshot below) 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.

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[Image: screenshot of ReSPECT form]

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Cambridge University Hospitals NHS Foundation Trust

ReSPECT guideline
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Resuscitation services/ safety and quality support

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 improve quality of life and control symptoms, but they may want to be considered for some life-sustaining treatments that have uncertain outcomes or benefits and may be unpleasant or uncomfortable. 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 with the purpose of controlling symptoms and providing 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 have uncertain outcomes with 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 including life sustaining treatments, but would not want to be on life support for a prolonged period without any hope of an improved quality of life or recovery.

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

These are the recommendations to guide decision-making in a future emergency that, in the clinician’s opinion, would help get the patient to the outcomes they desire, and prevent them from arriving at an outcome they fear. If the person does not have capacity to participate in discussing these recommendations, their family or other representatives should be involved in discussions whenever possible. It should be made clear that these are recommendations for care and treatment the patient would be considered for in a future emergency. A patient or their relative cannot demand treatment which the doctor does not believe to be clinically appropriate (Burke v The General Medical Council [2005]).

Start by deciding the goal of care as either focusing on life-sustaining treatment or focusing on symptom control by selecting one of the boxes.
**Clinical guidance:** Record clear detail of those types of care or treatment that the person would not want to be considered for and that would or would not work in their individual situation. Include, for example whether they should be considered for intensive care admission, or whether, for example only non-invasive ventilation would be recommended. If a patient is being discharged from hospital consider including whether or not the person would want to be taken back into hospital and in what circumstances.

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:** Tick 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 therefore not being offered, that should be explained in the context of the person’s priorities and goals of care.

The option of modified CPR is only for children. Further details of recommendations for modified CPR should be documented.

**Section 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.

If you tick that the patient does not have capacity to participate in making the recommendations documented on the ReSPECT form you will be asked to document the reasons for making this assessment.

Explain if there is an impairment or disturbance of the person’s mind or brain (documenting the suspected cause, eg reduced GCS, acute delirium, chronic confusion, etc.).

Document if this affects their ability to understand, retain, or weigh information relevant to the recommendations documented on the ReSPECT form, or to express their views, even after all communication strategies have been enlisted.

Do they have a legal proxy (eg welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations?
Section 6: Involvement in this plan

The clinician signing this plan: You must tick at least one of the statements A, B, C (+1,2,3) or, if none of those, D. Then record the date (or dates) of conversations about the recommendations and the names and roles of those involved. Make sure that details of what was discussed and agreed are documented in the clinical 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 the person who does not have capacity) 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.

Section 7: Clinicians’ signatures

The ReSPECT documentation should be completed by a doctor looking after the patient and the clinician’s signature recorded.

Any doctor competent to do so can have a discussion with a patient and can complete the documentation (following a conversation with the patient or those close to them). Decisions should be discussed with the consultant responsible for the patients care at the earliest opportunity and details for the senior responsible clinician recorded. It is good practice for a consultant to review decisions and to document this review.

If ReSPECT recommendations are completed on EPIC under a junior doctor’s sign-in (eg during a ward round), the name of the consultant responsible for the decision should be clearly documented.

Section 8: Emergency contacts (This section is only filled in on the paper form if this is completed on discharge).

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.

The ReSPECT order should then be completed by the doctor. The chart cannot be closed until the ReSPECT order is completed. The ReSPECT order can be completed by any doctor but if completed by a junior doctor, the name of the senior doctor who the decision has been discussed with (ST3 or above) should be documented.
OPTION 3: A ReSPECT conversation has previously been had. This will be reviewed and updated as appropriate.

If the ReSPECT form has previously been completed this will load automatically. All questions will be visible. The form should be reviewed and clinical information and recommendations updated as appropriate. Section 9 should be completed following review.

Section 9: Confirmation of validity

This section should be left blank at the time of initial completion of the plan. It should be completed on readmission to confirm previous details recorded on the ReSPECT form remain valid or when the form is reviewed due to a change in the patient’s condition. Remember to document in the health records whether and when review of the recommendations on this ReSPECT form should be considered.

If you think review will be required during this admission, it is important to document this in the notes. 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.

The ReSPECT order should then be completed by the doctor. The chart cannot be closed until the ReSPECT order is completed. The ReSPECT order can be completed by any doctor but if completed by a junior doctor, the name of the senior doctor with whom the decision has been discussed (ST3 or above) should be documented.

If there are changes made in the ReSPECT form a BPA order will be triggered and a new order will need to be placed.
9 How will recommendations regarding care and treatment be viewed in EPIC?

When all mandatory fields are completed a ReSPECT order must be placed. The correct order, based on the information completed in section 4 of the ReSPECT form, will automatically appear in the order set. These orders will be:

- Focus on life sustaining treatment + CPR attempts recommended = Active treatment, For attempted CPR
- Focus on life sustaining treatment + CPR attempts not recommended = Active treatment DNACPR
- Focus on Symptom control + CPR not recommended = Symptom Control DNACPR (Previously Optimal Supportive Care)
- Focus on life sustaining treatment + modified CPR = active treatment, modified CPR (for children only)
- Focus on symptom control + modified CPR = symptom control, modified CPR (for children only)

Once the order has been completed, the chart can be refreshed and the recommendations for treatment will be visible in the patient header, for example:
10 When should a decision not to attempt CPR be considered?

A decision that CPR should not be attempted should only be made after appropriate consultation and consideration of all aspects of the patient’s condition. A decision must be taken in the best interests of the patient, following assessment that should include likely clinical outcome and the patient’s known and ascertainable wishes.

When a decision about CPR is discussed, made and recorded, clinicians should try to be clear about the basis for the decision. For example, it may be made with and/or for:

1. a person who is at an advanced stage of dying from an irreversible condition, so CPR is inappropriate
2. a person who has advanced illness and deteriorating health such that CPR will not work
3. a person for whom CPR may be a treatment option with a poor or uncertain outcome
4. a person for whom CPR may work but is quite likely to restore them to a quality of life that they would not value.

In the first two of these CPR will not be successful and should not be offered or attempted. This should be explained to the patient, unless to do so would cause them harm. In the third and fourth cases, the wishes of the patient are paramount.

In 2014 the Court of Appeal concluded, in the case of Tracey V CUH Hospitals NHS Foundation Trust, that when a decision about CPR is being considered there should be a presumption in favour of patient involvement and that there need to be convincing reasons not to involve the patient in this decision. The patient should be involved unless it is considered that to do so is likely to cause the person to suffer psychological or physiological harm.

A subsequent High Court ruling in the case of Winspear v City Hospitals Sunderland NHSFT in 2015 stated that there should also be a presumption in favour of involving those close to an adult who lacks capacity in decisions relating to CPR, **whenever practicable and appropriate**. In most circumstances, if a patient is ill enough that you are concerned they might suffer a cardiac arrest, it is good practice to contact those close to the patient to inform them of the deterioration, and suggest they come into hospital.

A discussion about CPR would be appropriate in these circumstances. In the unusual event of an emergency CPR decision being made without those close to the patient being able to be reached, or if you consider it inappropriate to do so, make sure you document your reasons for not contacting them (or detail your failed attempts to contact them) clearly in the notes.
11 What happens if a patient has an existing DNACPR form?

If a patient is admitted into hospital with a valid community DNACPR form the decision documented on this form should be respected. The decisions should be recorded on EPIC using the ReSPECT process and documentation as soon as possible. Community DNACPR forms are often printed in black and white, and sometimes photocopied. They should be respected in whatever format, unless you have a high index of suspicion than they are fraudulent. We are unaware of such a case ever occurring.

The community DNACPR form (East of England form or other valid DNACPR document) is a patient held document and should be returned to the patient or their relative/carer, once a ReSPECT form and order has been completed in EPIC.

If it is appropriate for the patient to be discharged with a copy of their ReSPECT form the decisions will need to be transcribed onto a paper copy of the form ideally an original purple coloured one (see section 19 for more details).

12 What if a person doesn’t want a ReSPECT form?

If there is a clear clinical view that a ReSPECT form could be of benefit to them, the reasons for them not wanting this should be carefully explored and documented. Try to avoid using language such as ‘refused’. Try to offer them further opportunities to discuss this again (perhaps with a different clinician) or to change their mind as and when they are ready to do so.

13 What if the patient or those close to them disagree with recommendations for treatment and care?

In situations where the clinical team think that a particular treatment or intervention should not be initiated in an emergency because it will not work for the person all attempts should be made to explain this to the person or their representative. This should be done sensitively and carefully by an experienced, senior clinician. A second opinion should be offered if they do not accept the clinical decision. If disagreement persists, full details should be documented in their health record.

If necessary, legal advice and a ruling by the courts may be needed, but the need for this should be very infrequent if the person and those close to them have been properly involved in fully informed discussion.
14 **Do the recommendations on the ReSPECT form have to be followed?**

In certain situations healthcare professionals may decide not to follow the recommendations on a ReSPECT form. For example, if someone has a ReSPECT form stating that they would not want to receive attempted CPR, clinicians may feel that they have to give treatment if someone stops breathing as a result of choking, if they believe that that was not the circumstance envisaged when the person decided that they did not want CPR.

15 **What if there is doubt about a patient’s CPR status?**

In the event of an emergency situation, such as cardiac or respiratory arrest, occurring where there is any doubt regarding a patient’s CPR status, then full resuscitation should be commenced until the patient’s CPR status can be verified.

16 **What if a patient is undergoing a procedure which could precipitate a cardiac arrest such as a surgical intervention, angiography or cardiac pacing?**

Decisions not to attempt CPR should be reviewed in advance of the procedure taking place – ideally this should be discussed with the patient (or their representative should they lack capacity) as part of the consent process. The default position is that the decisions on the ReSPECT form should be suspended during surgical procedures.

Some patients may wish a decision not to attempt CPR to remain valid despite the presence of potentially reversible causes. If a patient wishes an advance decision refusing CPR to remain valid during a procedure or treatment that increases the risk of, or induces cardiac arrest and a clinician believes that the procedure or treatment would not be successful with the decision not to attempt CPR in place, it may be reasonable not to proceed.

17 **What if the patient suffers a cardiac or respiratory arrest from a readily reversible cause such as choking, anaphylaxis or a blocked tracheostomy tube?**

In such situations CPR would be appropriate while the reversible cause is treated – unless the patient has specifically refused intervention in these circumstances.
18 **Why is there no review date on the ReSPECT form?**

ReSPECT should be reviewed with each admission and according to each person’s individual situation (e.g., frequent review in an acute illness but not usually in an advanced, irreversible, terminal illness or stable long-term condition). The form should also be reviewed at the request of a patient who has changed their mind about their preferences for treatment.

A fixed review date risks:

- encouraging insufficiently frequent review for some people, especially those who are acutely ill and whose condition may change rapidly
- inadvertent ‘expiry’ (leading to disregard of the recommendations) for others whose recorded preferences and recommendations needed no review, and for whom repeated discussion and review would be burdensome.

Where an admission is for a frequently recurring, repeat treatment (e.g., dialysis or chemotherapy) then review on every admission is not required. In this situation the existing ReSPECT documentation should be considered valid and the recommendations followed.

19 **Discharging a patient with ReSPECT documentation**

The clinical team should ensure the ReSPECT recommendations remain valid at point of discharge, any indication that review is required should be observed and new recommendations documented to reflect any changes prior to discharge. It is good practice to discuss the ReSPECT recommendations again with the patient or those close them on discharge, particularly as the clinical picture may have changed, and the information needed for a community ReSPECT form may be different to that needed in hospital.

The details of the ReSPECT recommendations current at discharge will be communicated to the GP via the usual discharge paperwork through EPIC (**this information will be automatically transferred across to the discharge summary for the GP’s reference**).

If it is appropriate for the patient to be discharged with a copy of their ReSPECT form the decisions will need to be transcribed onto a paper copy of the form ideally a purple coloured one. There will be stock of these forms available on wards, available from the rapid response team, and some will be kept in the resuscitation services office on level 1.

Forms can also be printed from Connect [http://connect2/article/6117/ReSPECT](http://connect2/article/6117/ReSPECT)

Ambulance crews on discharge should accept non-coloured copies of the form. **IF** there are any queries from them, direct them towards the ReSPECT website [www.ReSPECTprocess.org.uk](http://www.ReSPECTprocess.org.uk) or the East of England Ambulance website where guidance can be found on ReSPECT for ambulance clinicians.
The patient should keep the ReSPECT documentation with them and ensure it is readily available for any health care professionals that may need to see it. It should accompany the patient at all times, and patients should ensure their family/ friends/ carers know about it and where to find it.

Any historical paper copy of ReSPECT documentation should have two lines drawn through and the word cancelled written, then these copies sent for scanning onto EPIC. Historical electronic versions of the form will be automatically archived.

20 What should happen if the patient leaves the ward to visit another department or for a home visit for example with an occupational therapist?

Staff in these other clinical areas must be aware of the ReSPECT recommendation so that they can respond appropriately in the event of an emergency situation.

Patients on home visits should be provided with a paper copy of the ReSPECT documentation in case of an emergency whilst they are outside of the hospital.

21 What’s the difference between ReSPECT and an Advance Decision to Refuse Treatment (ADRT)?

A ReSPECT form communicates overall goals of care, is rapidly recognised in an emergency and, like a DNACPR or UFTO, is not legally binding.

An ADRT is a legal document that people in England & Wales can complete to refuse treatment that they don’t want to receive. If it is completed according to the Mental Capacity Act 2005 it is legally binding.

A ReSPECT form can be used to draw attention to the presence of an ADRT and should contain relevant aspects within the summary recommendations for treatment and care.

More information on ADRTs can be found in the MCA policy available via: http://connect2/article/1811/Mental-Capacity

22 What’s the difference between ReSPECT and an advance or anticipatory care plan (ACP)?

A ReSPECT form is a very specific type of ACP that summarises the emergency care aspect of a wider advance or anticipatory care planning process. ReSPECT records that information so as to make it accessible rapidly to professionals who need to make immediate decisions about care and treatment in a crisis.

An ACP is made with people who are able and willing to think ahead to a time in their illness when they may be unable to express their preferences. An ACP
document is usually longer and more detailed than ReSPECT. It is not restricted to planning for an emergency, and is likely to contain information about preferences such as self-management plans, place of care preferences, funeral plans, understanding of prognosis, details of financial and welfare power of attorney.

ACP and ReSPECT are entirely complementary. They may be developed together, from the same conversations, or development of one may prompt people to discuss the other.

23 How does ReSPECT differ from an end-of-life care plan?

Use of and potential benefit from the ReSPECT process is not restricted to people with life-limiting illnesses or those in need of end-of-life care. A person’s ReSPECT form summarises treatments to be considered and those that would not be wanted or would not work in an emergency.

End-of-life care plans record a more detailed plan, setting out a person’s individual care and treatment needs as they approach the end of their life, and are not limited to recommendations for use in an emergency.

For people approaching the end of life, the two plans can be complementary. Care must be taken to ensure that both types of plan address the specific needs of each individual. More information is available via the link: http://merlin/Lists/DMSRecords/DispRecordTabsDoc.aspx?ID=18346

24 Useful contacts

Patients and relatives: If you have any queries about the ReSPECT process or form that has been completed for you or your relative, please discuss these with the clinicians involved in your care on the ward.

Staff: Contact resuscitation services on extension 217390.

More information can also be found on Connect

http://connect2/article/6117/ReSPECT

or via the website www.respectprocess.org.uk

25 Monitoring compliance with and the effectiveness of this document

Compliance with this guidance will be routinely assessed on a quarterly basis by the completion of a Trust-wide audit. The resuscitation services lead is responsible for organising this in conjunction with staff from relevant departments. The audit covers several key standards, a summary of which follows:
Resuscitation services/ safety and quality support

- Location of documentation: Knowledge of where paper forms can be found – 100%
- ReSPECT Form found in ward round/ admission navigator on EPIC – 100%

1b: Patient Demographics correctly recorded – 100%
2a: Relevant information (including diagnosis) completed – 100%
2b: Relevant information (including organ donation wishes) – 100%
4a: either ‘Focus on life sustaining treatment’ or ‘Focus on symptom control’ selected – 100%
4b: Some clinical guidance recommended – 100%
4c: One CPR Recommendation recommended and signed – 100%
5a: Mental Capacity documented – 100%
5b: Of those patients where ‘NO’ has been circled, mental capacity assessment is completed on EPIC – 100%
6a: Selection one of options A-B boxes—100%
6b: Where ‘D’ is circled, there must be an explanation – 100%
6c: i) date of discussions documented – 100%
   ii) names if those involved documented – 100%
   iii) roles of those involved documented – 100%
   iv) where details of the full discussion can be found is documented – 100%
7a: Clinicians details documented, including – 100%
   i. Designation
   ii. Name
   iii. GMC/NMC/HCPC Number
   iv. Signature
   v. Date/ time
   vi. Senior Responsible Clinician
8a) Emergency contacts documented, including – 100%
   i. Name
   ii. Telephone
9a) Confirmation of validity (on review), including – 100%
   i. Review Date
   ii. Designation
   iii. Clinician Name
   iv. GMC/NMC/HCPC Number
   v. Signature
The draft audit report is subsequently presented to members of the resuscitation committee who discuss and agree any necessary actions required to address issues which may have arisen. The final report (along with any necessary recommendations) is then released Trust-wide by resuscitation services on behalf of the committee. The report is circulated at chief executive level downwards through the directors, senior clinical nurses and ward managers, with a request to cascade the information to all clinical staff and ensure the recommendations/ issues are addressed.

If particular recommendations have been agreed, staff from resuscitation services will follow these up and ensure they have been actioned in the clinical areas. The resuscitation services lead is responsible for reporting progress back to the resuscitation committee at the quarterly meetings.

26  References


R (On the application of Burke v The General Medical Council [2005] EWCA Civ 1003

Tracey, R (on the application of) v Cambridge University Hospitals NHS Foundation Trust & Anor [2014] EWCA Civ 33 (24 January 2014)

Winspear v City Hospitals Sunderland NHSFT [2015] EWHC 3250 (QB)

27  Associated documents

- Adult patient transfers (internal and external) procedure
- Anaphylaxis: first response treatment of anaphylactic reactions policy and procedure
- Guidance notes for completing the paediatric resuscitation plan
- Organ donation documents
- Paediatric patient transfers (internal and external)
- Mental Capacity Act [including Deprivation of Liberty Safeguards (DoLS)] policy
- Withdrawal of treatment and end of life in critical care guideline
Resuscitation services/ safety and quality support

Equality and diversity statement
This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

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Appendix 1: ReSPECT EPIC workflow
Appendix 2: Paper ReSPECT form