Leicester, Leicestershire and Rutland (LLR)
Working in Partnership Across Services

Recommended Summary Plan for Emergency Care and Treatment

Policy for use across all providers in Leicester, Leicestershire and Rutland (LLR)

Approved By:	Organisational Policy & Guideline Committees
Date Approved:	**17 January 2020** (UHL Policy and Guideline Committee)
Organisational/Trust Reference:	E1/2020
Version:	One
Author Originator(s):	LLR ReSPECT Implementation Group
Name of Review Group	LLR End of Life Working Group
Next Review Date:	May 2026 **12-Month Review Date Extension Approved at PGC on 02/05/2025**

Index

Leicester, Leicestershire and Rutland (LLR)
Working in Partnership Across Services

Forward

Leicester, Leicestershire and Rutland (LLR) will implement ReSPECT across all services as of 01/01/2020. This policy has been agreed by all main stakeholders to aid clear communication of patient's wishes across organisational boundaries, to promote safe and effective care delivery.

This policy applies to patients of all ages, and is supported by individual organisational addendums to aid direct care delivery where required. The following Working party representatives have agreed to use of this policy within their organisations as required. This policy will be reviewed via organisational Resuscitation groups or designated organisational reviewers. Any amendments required must be agreed with the LLR End of life Working Group and copies of the updated policy shared across the organisations below.

Organisation	Representative	Representative Agreement
Leicester Partnership NHS Trust	Caroline Barclay Consultant Nurse CHS	
University Hospitals of Leicester NHS Trust		
East Midlands Ambulance Service		
LOROS		
Leicestershire County Council	Ros Speight Josephine Mclean	
West Leicestershire CCG	Carole Ribbins	
Leicestershire City CCG		
East Leicester and Rutland CCG		
Derbyshire Health Care		

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treatment is no longer justified (BMA, RC (UK) RCN 2007), even potentially life-saving treatment can be withheld or withdrawn if it is not in the patient's best interests and the patient lacks capacity to make that decision for themselves at thattime.

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 'Advanced Care 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?

1.1.1 ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment see Appendix 1 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 recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stops

1.1.2 In the event of Children defined as those under the age of 18 in England a recommendation for Modified CPR may be requested. This must be supported by a Children and Young persons Advanced Care plan (CYPACP) to aid clarity for the patients, family and health professionals. DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) For Children and Young Adults Aged Under 16 Years UHL Policy.pdf

1.2 How does it work?

1.2.1 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 wi t h people with parental responsibility, and/or where appropriate the young person themselves. The plan should remain 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.

1.2.2 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?

1.3.1 A ReSPECT conversation follows the ReSPECT process by:

- Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future
- Identifying the person's preferences for and goals of care in the event of a future emergency
- 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
- 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
- Making and recording a shared decision about whether or not CPR or modified CPR is recommended

1.4 Cardiopulmonary resuscitation

1.4.1 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.

1.4.2 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.

1.4.3 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 deterioration in their condition and who competently refuse these treatment options.

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

1.5 Glossary

1.5.1. 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).

1.5.2. 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 donot.

1.5.3. 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.

1.5.4. 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. Please refer to 1.5.8 Mental Capacity Act (MCA) as refers to the same policy

1.5.5. 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 byit.

1.5.6. Modified Cardiopulmonary Resuscitation

Modified CPR normally applies to children under the age of 18. Clear instructions documented within a CYPACP outlines what attempts should be undertaken.

1.5.7. 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.

1.5.8. 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 majorsurgery.

1.5.9. Lasting Power of Attorney

A person given this power under the Mental Capacity Act 2005 has the ability to make certain decisions on behalf of a person who lacks capacity to do so. The LPA may have decision making power relating to 'health and welfare', and/or to 'property and finances'.

1.5.10. ReSPECT

Recommended Summary Plan for Emergency Care and Treatment 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.

1.5.11. Resuscitation

Resuscitation is a 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.

1.5.12. Advance Decision to Refuse Treatment (ADRT)

A legally binding means through which a person who has capacity to do so, may ensure that they will not receive certain treatments when they lack mental capacity to decide for themselves providing that certain criteria are met. Please refer to the Mental Capacity Act 2005, and local policy, for further information.

1.5.13. Best Interests

An objective measure of overall benefit to a particular person. Under the Mental Capacity Act 2005, decisions made on behalf of people who lack mental capacity to do so themselves, must be made in their 'best interests'.

This includes a 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.

1.5.14. Healthcare professional with overall clinical responsibility

The healthcare professional involved in a person's care who is ultimately professionally responsible for a person's healthcare in a given setting. This person will also be professionally responsible for engaging in the ReSPECT process and documentation for that person. For example, in a hospital, this will usually be the named consultant.

1.5.15. Children's and Young Persons Advanced Care (CYPACP)

A document designed to be a holistic, summary document that facilitates the clear and concise communication of the wishes of children or young people (and their families), who have chronic and life-limiting conditions. The framework can be used for discussing and documenting the agreed wishes of a child or young person and his or her parents, when the child or young person develops potentially life-threatening complications of his or her condition and sets out an agreed plan of care to be followed when a child or young person's condition deteriorates. It is designed for use in all environments that the child encounters: home, hospital, school, hospice, respite care, and for use by the ambulance service and remains valid when parent(s) or next of kin cannot be contacted. It incorporates the ReSPECT form as a summary for those geographical areas where ReSPECT has been adopted.

1.5.16 Emergency Healthcare Plan / Personal Resuscitation Plan (EHCP/PRP)

The Emergency Healthcare Plan / Personal Resuscitation Plan is a medical care plan and is the responsibility of the child / young person's consultant. It is their plan of best care for their patient. EHCP/PRP still valid if written prior to 01/01/2020 with an expectation they will be reviewed and transferred to CYPACP with ReSPECT when the child or young person has their next medical review.

2. General principles

2.1 This policy is intended for anyone, of any age 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 may 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 Leicester, Leicestershire and Rutland (LLR).

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

2.3 This policy applies to the whole multidisciplinary healthcare team involved in the patient's care. Leicester, Leicestershire and Rutland have agreed Purple or Black and white forms ReSPECT Forms will be accepted and deemed valid. Where possible these should be held within a plastic wallet with a copy of any relevant ACP/EHP – Emergency Health Plan/ CYPACP – Children and Young Peoples Advanced Care Plan /or EHCP – Emergency Health Care Plan.

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 cardiorespiratoryarrest.

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 beappropriate.

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 emergencysetting.

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. 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.

2.9 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 favor 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. Please refer to section 6 "Situations where there is a lack of agreement"

2.10 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 favor of involvement of the person in the decision-making process.

2.11 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 berespected.

2.12 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 finaldecision-makers.

2.13 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 lacksuchcompetence.

2.14 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 forthat.

2.15 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.

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

2.17 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 understanding about what has been explained to them.

2.18 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 theMCA

2.19 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 seriousharm.

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

2.21 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.

2.22 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. Please refer to section 6 "Situations where there is a lack of agreement"

2.23 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 ReSPECTform.

2.24 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.

2.25 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

2.26 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 favor 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 considered.

2.27 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.

2.28 The original ReSPECT form must accompany the patient at all times. If faced with different versions of the document, whether electronically or in paper copy, the decision-maker should check the date of completion of each form, and proceed in accordance with the most recently completed valid and applicable version; this is likely to be the version that accompanies the person. When possible and appropriate, any obsolete versions should be clearly cancelled, and a full record of events made in the person's current healthcare record.

3. Stakeholders Organisations

- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust
- East Midlands Ambulance Service
- LOROS
- Leicestershire County Council
- Leicestershire West/City/East and RutlandCCG
- Derbyshire Health Care
- Leicester City Council
- Leicestershire County Council
- Rutland County Council
- General Practice

4. Legislation and guidance

4.1. Legislation

4.1.1. 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.

4.1.2. 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 (article3)
- 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 freefrom discriminatory practices in respect to those rights (article 14)

4.1.3. 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.

4.1.4. 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

4.2.1. 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 availableat http://resus.org.uk/dnacpr/decisions-relating-to-cpr
- Further information about ReSPECT is available at https://www.resus.org.uk/respect/
- For further information on the guidance on the CYPACP see http://cypacp.uk/document-downloads/policy

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 should be used and accepted by all providers across Leicester, Leicestershire and Rutland.

5.6. During transition from DNAR-CPR forms to ReSPECT and EHCP to CYPACP and ReSPECT in the case of children and young people LLR has agreed all forms are deemed valid if fully completed in line with individual organisational policy.

5.7. 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.

5.8. 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.

5.9. For Children and Young People the CYPACP/ReSPECT or EHCP/PRP should not be photocopied once distributed as will be difficult to cancel all copies of the plan if rewritten in the future. The only CYPACP/ ReSPECT or EHCP/PRP which should be followed is the plan with the child as will be the most up to date document. This on occasion may be in black and white but professionals will endeavor to ensure it is in colour where able. Parents can change their minds at any time and so can request that full resuscitation is carried out even when the most up to date CYPACP/ReSPECT or EHCP/PRP states that modified CPR or DNAR/CPR is agreed.

5.10. 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.

5.11. The healthcare professional completing the ReSPECT form should fill in their details and sign the form. The ReSPECT form is valid as long as it is signed by the person completing the form, The escalation and resuscitation decision must be discussed and agreed with the senior clinician responsible for the patient's care as soon as practically possible. 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 and agreed with should be clearly documented in the patient's medical notes and the from signed when practicallypossible.

5.12. Guidance for clinicians on how to complete the various sections of a ReSPECT form can be found in Appendix 4. 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/. Leaflets agreed for use across LLR are enclosed in Appendices 5 – 9.

5.13. Healthcare professionals, involved in the person's care, other than those with overall clinical responsibility for the care of a person may complete or make minor amendments to a ReSPECT document. Significant amendments must not be made to the document; instead, the document must be cancelled and a new one instated. In these situations, the healthcare professional must discuss amendments with the clinician with overall clinical responsibility and document discussion within the patient's medical records.

5.14. Upon discharge from a healthcare setting the healthcare team caring for the person should review their ReSPECT document to check the recommendations remain appropriate and that the ReSPECT document travels with them to their new setting. The recommendations must be communicated within the dischargeletter.

5.15. 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 or record agreement within the electronic record.

5.16. There is no formal review date for a person's ReSPECT document. The nature of any review will depend on the particular clinical circumstances of the person. It is recommended the document is reviewed regularly as part of routine healthcare, in relation to a significant change in a person's health status or at the request of the person or their representative. All formal reviews of a person's ReSPECT document must be either evidenced by a signature of the reviewer, in the relevant section of the document or a recorded within the person's medical records dependent on healthcare setting.

5.17. 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 a review is offered and that it has taken place, unless there is good reason for it not to have takenplace.

5.18. Minor amendments may be made to a person's ReSPECT document by a healthcare professional (if dated, timed, and signed by the person amending the document), if the contents of a ReSPECT document need to be changed significantly, the old ReSPECT document must be cancelled, and a new ReSPECT document completed.

5.19. Following transfer the responsible senior clinician should review and endorse the form as soon as practically possible and countersign the form in the space provided. If a signature is already present in the senior responsible section then the escalation and Resuscitation decisions within the ReSPECT form should be discussed with the new senior responsible clinician and section 9 should be completed acknowledging agreement. This should be documented in the patient's medicalnotes.

5.20. 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, scanning or telephone), in line with local procedures.

5.21. A person's ReSPECT document, including CPR/ DNACPR status, must be communicated between healthcare professionals whenever a person is transferred between healthcare settings, or between different areas or departments in the same healthcare setting, or is admitted or discharged.

5.22. As the ReSPECT document is a summary document of discussions and plans that may have been made over a period of time, it is important that more detailed information is also shared between healthcare settings.

5.23. Where a person has a shared electronic patient record or has consented to be on the electronic end of life register (EPaCCS), an alert should be set up on this record indicating the existence of the ReSPECT document and including reference to the person's CPR/ DNACPR status. Detail of the information contained within the ReSPECT document must also be included in the electronic record and keptup-to-date.

6. Situations where there is a lack ofagreement

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 thenotes.

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

6.5. However in the case of a child or young person any difference in opinion between parents and professionals about what treatment is clinically appropriate or not, must be reviewed by the multidisciplinary team to reach a consensus. If there is no consensus then a second opinion will be needed. If disagreement persists following a second opinion then further advice should be sought from the Paediatric clinical teams involved (both in LLR and in acute venues).

6.6. 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 organisations legal representatives. The possibility of application to court exists as a last resort to resolve disputes and legal advice should be obtained with that inmind.

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 relevant professional 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 and update the patient's record accordingly.

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

7.4. It is vital that children and Young people always carry the most up to date Advanced care plan with them at all times so that any changes in decision are immediately available to clinical staff.

8. Temporary suspension of emergency care and treatment decisions

8.1. In some circumstances there are reversible causes of 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 anesthesia, 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 reversiblecause.

8.4. After the event, the ReSPECT decisions should be reviewed and discussed with the

patient and reinstated where appropriate.

9. ReSPECT for people who lack mental capacity to make decisions about care and treatment in emergency situations

9.1 The ReSPECT document may be used to document plans for emergency and potentially life-sustaining treatment, including CPR, for those who lack mental capacity to make these decisions for themselves.

9.2 The Mental Capacity Act 2005 (MCA) provides the legislative framework for stipulating how people who lack the mental capacity to make certain decisions are treated, in England and Wales. Please refer to the MCA and local policy for further information on the requirements of the Act, including about when and how to assess a persons' mental capacity, when and how to make decisions that are in the best interests of a person who lacks mental capacity, and when and how to involve advocates and proxy decision-makers in relevant decisions. The Act sets out five 'statutory principles' – the values that underpin its legal requirements:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- 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.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- 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.

9.3 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.

9.4 For more information on the requirements of the Act please refer to the MCA Code of Practice and local policy. Clinicians involved in the ReSPECT process must 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.

9.5 If a person over the age of 16 lacks mental capacity to make a particular decision under the MCA, any decisions regarding treatment they receive must be in their best interests, unless the decision is covered by a legally valid and applicable advance decision refusing the treatment.

9.6 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.

9.7 The person's mental capacity, lack thereof, and/or the presence of a proxy decision-maker (e.g. a donee of Lasting Power of Attorney with relevant legal powers), must be recorded in the ReSPECT document in addition to any other part of the person's current healthcare record as determined by localpolicy.

10. Operational Responsibility

10.1 Individual organisations should add specific addendums to this policy as applicable to aid direct care delivery within their areas of practice. These will be colour coded for ease of access.

10.2 This policy should be submitted in line with via individual organisational requirements for ratification.

10.3 Individual organisations will need to stipulate roles and responsibilities in relation to education, dissemination and monitoring compliance of this policy.

10.4 Each provider organisation should ensure 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).

10.5 Future amendments should be reviewed through internal Trust groups e.g. Resuscitation Committee and agreed across LLR via End of life Steeringgroup

10.6 Individual organisations should outline their training and on-going monitoring requirements.

11. Training

11.1 Decision-making around CPR and other emergency treatment planning requires knowledge, skill and confidence in relation to relevant legal and ethical principles, communication, and good documentation. Although these aspects of clinical care are not specific to the ReSPECT process, they are essential for its success. Each organisation must stipulate there individual training requirements for staff completing theforms.

11.2 Healthcare providers must link the use of ReSPECT into existing mandatory training for their clinical staff. All healthcare staff should be trained and supported to enable safe and effective use of the ReSPECT document, and attendance at this training recorded locally. Familiarisation of the ReSPECT process, and documentation should also form part of all relevant resuscitation training. Each organisation must stipulate there individual training requirements for staff.

Leicestershire Partnership NHS Trust (LPT) Training Requirements

	No training implications identified
	ReSPECT Training
	☐ *Mandatory (must be on mandatory training register)* X *Role specific* ☐ *Personaldevelopment*
	X *Adult Mental Health & Learning Disability Services* x *Community Health Services* *x Enabling Services* x *Families Young People Children* *x Hosted Services*
	Patient facing clinical staff
	Annual
	Resuscitation team
	N/A
	yes
	X ULearn ☐*Other (please specify)*
	Workforce training reports

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

Leicestershire Partnership NHS Trust

There are currently two valid forms within Leicestershire Partnership NHS Trust (LPT) to reflect escalation and resuscitation decisions – ReSPECT and East Midlands Unified Do Not Resuscitate Forms (Red Bordered).

This policy replaces the DNA-CPR policy but it is acknowledged that DNA-CPR only forms and ReSPECT documents will co-exist particularly in community settings for some time.

DNAR-CPR only forms are still valid but no new DNAR-CPR only forms should be generated within LPT after 01.01.2020.

1.0 Escalation and Resuscitation Discussions

1.1 The Trust has a legal duty to consult with and inform patients if a ReSPECT/DNACPR order is placed in their notes.

1.2 In the rare event that an escalation and resuscitation decision is made, and there has been no discussion with the individual because the doctor considers that consultation would be distressful and such distress could cause physical or psychological harm, this must be documented in the patient's clinical record.

1.3 Every effort should then be made to discuss with the patient's relatives/next of kin with the patient's permission dependent on the patients mental capacity.

1.4 The LPT DNA-CPR and ReSPECT patient information leaflet should be made available, where appropriate to patients and their relatives or carers.

2.1 Roles and Responsibilities

2.2 Chief Executive

The Chief Executive has overall responsibility for Trust compliance with this Policy and procedures

2.3 Medical Director

The Medical Director is responsible for making arrangements to support the safe and effective implementation, monitoring and review of this policy.

2.4 The Deteriorating Patient and Resuscitation Group

The deteriorating patient and resuscitation group which meets bimonthly, acts as a decision-making body for development and implementation of operational policies relating to resuscitation.
The group, supported by the Resuscitation Lead, is responsible for:

a) Continuing to develop this policy.

b) Consideration of educational needs.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

c) Monitoring compliance with this policy.

d) Review of this policy.

2.4 Directors and Heads of Nursing in each Directorate are responsible for:

a) making sure that all staff in their Directorates are made aware of the policy and procedure for completion of a ReSPECT form.

b) making sure that staff groups and individuals are given appropriate training to complete and assess the validity of the ReSPECT and DNAR-CPR only form .

c) managing the effectiveness of this policy through a robust system of reporting, investigating and recording incidents, audits of LPT ReSPECT and DNAR-CPR only forms and report any concerns / issues to the Directorate Governance groups.

d) ensuring process are in place to undertake audits of compliance, results reviewed and actions taken to address any areas of non-compliance.

2.5 Ward Managers, Heads of Service/Department are responsible for ensuring:

a) staff and trainees are aware of the LPT ReSPECT Form, policy and the East Midlands unified DNA-CPR form.

b) staff and trainees have had the opportunity to attend the appropriate level of training as part of their contract of employment.

c) review of audit results and actions taken where applicable.

2.6 Consultants/Associate Specialists/ Allied Health professionals are responsible for ensuring:

a) Escalation and Resuscitation decisions are considered, dependent upon a patient's individual circumstances and preferences.

b) Escalation and Resuscitation discussions with patients and relatives/carers are undertaken in line with this policy and documented accordingly in the patients' records where applicable.

c) The DNA-CPR only or ReSPECT form is correctly completed and reviewed, if appropriate.

d) Any Escalation and Resuscitation decisions originating within LPT that are not made by either a Consultant or Associate Specialist shall be discussed and verified with the responsible consultant within 72 hours.

e) Review ReSPECT and DNA-CPR orders as appropriate.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

f) Healthcare professionals making an Escalation and Resuscitation decision or completing a ReSPECT Form should be a Consultant/Associate Specialist/ Middle Grade Doctor, or Allied Health Professional that has undertaken the required training. For children and young people this should be the Lead Consultant or GP usually with support from the Diana Children's Community Nurse.

2.7 All professionals must:

a) Have undertaken appropriate training and education in communication and resuscitation decision making, in line with this policy.

b) Explanation of the decision should be discussed with the patient ensuring every effort is made to involve the patient in the decision and involvement of their relatives/carers where appropriate.

c) In the case of children using the CYPACP document may be most effective when drawn up by child/young person and their parents/guardian with a doctor who they know and who has known the child, and in advance of any life threatening event if possible.

c) Document discussions with the patient and relative/carer or provide rationale if no discussion has taken place.

d) Document the discussion and decision on the ReSPECT/DNA-CPR / EHCP/PRP/CYPACP form in both patient notes and electronic records.

e) Discussions should also include other professional's central to the care of the child (i.e. GP, system specific specialist nurses, hospice staff etc.). Effectively communicate the decision to the rest of the team.

f) The process may involve several different discussions over a period of time as it is essential that all concerned in the decision-making process are allowed enough time for information to be given and understood, to consider, to ask questions and to express their opinion. Review the decision if necessary.

g) The responsible clinician making the decision must sign and date the completed form.

h) The child / young person and or parents / guardian can also sign, but do not have to, as they can over-ride this written plan at any time for any reason, i.e. they can change their minds and verbally ask for a different action e.g. more or less intervention.

i.) Include information regarding a DNA-CPR/ReSPECT decision in pre-admission documentation

2.8 All LPT Clinical Employees are responsible for:

a) Adhering to this policy and supporting procedures.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

b) Notifying their line manager of any training needs and for undertaking relevant training.

c) Ensuring they are aware of the existence of a ReSPECT/DNA-CPR / CYPACP EHCP/PRP decision.

d) Checking the validity of a ReSPECT/ DNA-CPR / EHCP/PRP/CYPACP documentation.

e) Communicating the existence of a ReSPECT/DNA-CPR / EHCP/PRP/CYPACP decision at handover.

f) Notifying other services of the ReSPECT/ DNA-CPR / EHCP/PRP/CYPACP decision on the transfer of the patient – both internally and externally.

g) Participating in the audit process and acting on the results accordingly.

h) Under the Mental Capacity Act (2005), staff are expected to understand how the Act works in practice and the implications for each patient for whom a ReSPECT/DNA-CPR / EHCP/PRP/CYPACP decision has been made.

3.0 Lack of Capacity

3.1 If a patient lacks mental capacity to make a decision regarding escalation and resuscitation, then a discussion about escalation and resuscitation status should be with the next of kin, family or carers as appropriate

3.2 Any Advance Decision to Refuse Treatment remains legally binding and enquiries should be made as to whether there is a Lasting Power of Attorney / Personal Welfare Attorney appointed. These are permitted to make decisions about treatment if the patient lacks capacity.

3.3 If the patient is deemed to be unfriended, then the 'decision maker' has a legal duty to instruct and consult an Independent Mental Capacity Advocate (IMCA) in the decision. The decision maker in this case will be the consultant in charge of the patient's care.

3.4 If an escalation and resuscitation decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and the reasons for it should be recorded in the patient's notes and an IMCA should be consulted at the first available opportunity.

3.5 An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician responsible for the person's care as part of the determination of that person's best interests.

3.6 It is not the IMCA's responsibility to make the escalation and resuscitation decision. The decision remains the clinical decision maker's responsibility. However, the IMCA must be instructed and consulted, as above, as part of the determination of that person's best Interests.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

3.7 Please refer to LPT's Mental Capacity Act Policy for further guidance. https://esource.leicspart.nhs.uk/Library/MentalCapacityActPolicyexpMar21.pdf

3.8 The discussions must be documented within the contemporaneous medical records. Where contact has not been possible, details of attempts made and consideration of alternatives, or the need for urgent/emergency decision making must also be documented in the patient's records.

3.9 It is important to note that the person's ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when an escalation and resuscitation decision is reviewed, staff must consider whether the person can contribute to the decision-making process each time.

4.0 Ongoing use of ReSPECT and DNACPR only forms

4.1 Patients or their relatives may not agree with a DNACPR decision being made even if the clinical evidence suggests that CPR will not succeed. Sensitive discussion with the person should aim to explore and support their understanding. The senior responsible clinician or their overseeing colleague should be involved in this discussion.

4.2 Individuals cannot demand that healthcare professionals carry out treatment against their clinical judgement. In the event that a patient disagrees with the decision a second opinion MUST be sought and the escalation and resuscitation decision suspended during the time of seeking that second opinion.

4.3 Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought from the LPT Legal Services

4.4 The ReSPECT document and DNA-CPR decision-making process is monitored and evaluated as per LPT's auditing programme, to ensure a robust governance framework is undertaken. These results are reviewed by the deteriorating patient and resuscitation group and reported to Patient safety improvement group (PSIG).

5.0 Cancellation of a valid ReSPECT form indicating the patient is not for CPR or a valid DNACPR only form.

5.1 In some circumstances, it may be appropriate to cancel the ReSPECT form or DNACPR only form. It is the responsibility of the healthcare professional cancelling the decision to communicate this to all parties informed of the original decision and document in the contemporaneous notes.

6.0 Unexpected Deterioration

6.1 In a situation where a patient is deteriorating rapidly and a decision regarding escalation and resuscitation is required as an emergency to avoid inappropriate attempts at resuscitation, attempts should be made to contact medical staff, an Advanced Clinical Practitioner or other registered healthcare professional with the appropriate competence, training and experience to attend the patient immediately.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

6.2 If the attending doctor, Nurse or healthcare professional does not have the necessary competence, training and experience they would be expected to make an assessment and to discuss with an experienced senior healthcare professional with the necessary competence, training and experience.

6.3 If the doctor, Nurse or healthcare professional is unable to attend immediately, the decision about escalation and resuscitation must be made if necessary over the telephone weighing up the clinical information available. Decision-making must still be in line with the MCA and the decision explained to the patient and family by the team member as soon as possible.

6.4 A full record of the discussion must be recorded in the notes and a ReSPECT document completed.

6.5 Any ReSPECT form originated within LPT should be discussed with the responsible clinician within 72hrs and a record documented within the medical notes to reflect this. The forms must be countersigned as soon as possible. Forms are valid as long as signed by originator.

6.6 In the event of an unexpected cardiac arrest, there should be a presumption FOR CPR and every attempt to resuscitate the individual will take place in accordance with the 'Cardiopulmonary Resuscitation Combined UHL LPT LLR Policy' and with the Resuscitation Council (UK) guideline, unless a valid ReSPECT form indicating the patient is not for CPR or a valid DNACPR is in place, or an appropriately qualified healthcare professional (i.e. qualified to certify death) determine that continuing CPR is not in the patient's best interests or it is unlikely to be successful in the clinical situation.

6.7 In the community there will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies (NMC, BMA). In these circumstances please contact the GP for verification and /or certification.

7.0 Communication

7.1 Patients admitted with a ReSPECT form must have a copy of the ReSPECT form uploaded to their electronic medical records if a copy is not already present. The original form should be kept at the front of the paper-lite notes whilst an in-patient and given back to the patient on discharge

7.2 All resuscitation and escalation decisions should be reflected within the patients electronic records and electronic observations systems where applicable

7.3 Any Respect forms originated within LPT must be given to the patient in the designated plastic wallet along with their ACP/ECP/CYPACP if applicable on discharge. If an electronic version is used this must be printed off and given to the patient.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

7.4 All escalation and resuscitation decisions and any associated ACP/ECP/CYPACP should be communicated to the responsible clinical staff on discharge from our care. This may be the GP and community staff if the patient is discharged home or to a care home or other acute care providers if admitted to secondary care.

8.0 Education and Training Requirements

8.1 All staff should undertake mandatory training and supplement with further training appropriate to their role.

8.2 All staff involved in the care of patients must complete ReSPECT Level 1 awareness training. On-going awareness training is provided via Basic Life Support and Immediate Life support for all health professionals.

8.3 For health care professionals where completion of ReSPECT documents is specifically required for the role, they must complete Level 2 ReSPECT Training. Allied health professionals are required to complete additional competencies outlined below in this document.

9.0 Children and Young People

THE CHILDREN AND YOUNG PEOPLE'S ADVANCE CARE PLAN (CYPACP) WHICH INCORPATES THE RESPECT DOCUMENT WILL BE IMPLEMENTED FROM 01.01.2020.

PREVIOUS EHCP/PRP'S WILL REMAIN VALID BUT THERE IS AN EXPECTATION THAT CONSULTANTS UPDATE ONTO THE NEW PAPERWORK WHEN REVIEWING THE CHILD/YOUNG PERSON.

9.1 For children and young people the appropriate healthcare professional should be the Lead Consultant or GP usually with support from the Diana Children's Community Nurse.

9.2 The CYPACP may be most effective when drawn up by child/young person and their parents/guardian with a doctor who they know and who has known the child, and in advance of any life threatening event if possible.

9.3 Discussions should also include other professional's central to the care of the child (i.e. GP, system specific specialist nurses, hospice staff etc.). Effectively communicate the decision to the rest of the team.

a) Young people who do not have an East Midlands Emergency Health Care Plan started before their 16th birthday should be managed in accordance with the ReSPECT policy as with adults, decisions about CPR must be made on the basis of an individual assessment of a young person's current situation.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

b) If a 16 or 17 year old is thought to lack capacity for a decision there is no requirement to consult an IMCA where there is a parent available for **consultation and there are no safeguarding concerns arising in connection with that parent. The parents are able to provide consent under the normal arrangements of the Children Act.**

c) There is no provision in the Mental Capacity Act (2005) for young people aged 16 and 17 to appoint Lasting Powers of Attorney, or to make an Advance Decision to Refuse Treatment (ADRT).

d) The Mental Capacity Act (2005) runs 'parallel' with the Children Act (1989), and the two statutes are drawn up in such a way as to co-exist, rather than provide contradictory advice.

9.4 There will be times when it is not clear whether a clinical problem should be approached via the children Act or the Mental Capacity Act. If there is any uncertainty, or if it is not possible to reach agreement between the patient, the individuals with parental responsibility and the healthcare team, legal advice should be obtained.

10.1 CYPACP Specific Guidance

- There is no fixed expiry time on an EHCP/PRP.
- A review date for a CYPACP or DNACPR decision should be specified by the senior clinician at the time of completing the documentation if applicable.
- CYPACP's should be reviewed at least annually, but do not have to be discussed with the family at each appointment or hospital admission.
- The date for review, or 'no review required' must be documented on the CYPACP document and also in the patient's clinical record.
- The CYPACP must specify a named health care professional who is responsible for keeping the plan up-to-date.
- Review meetings need to be organised well ahead of time to ensure there is always a current valid plan.
- The parents/child can ask for a review of the CYPACP or DNACPR decision at any time.
- For example, they may wish to consider different treatment options. This discussion will be with the Consultant Paediatrician.

If the CYPACP including ReSPECT has a review date but is not reviewed at the stated date, the CYPACP or DNACPR form becomes invalid.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

11.0 Equality Statement

11.1 eicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

11.2 It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

11.3 This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

11.4 In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

11.5 This applies to all the activities for which LPT is responsible, including policy development and review.

12.0 Due Regard for Equality

12.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified. See Due regard Assessment

12.2 The following sections of the Human Rights Act (1998) 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)

13.0 Legal Liability

13.1 The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure thatthey:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

14.0 Process for Monitoring Compliance and Effectiveness

14.1 Compliance with this policy will be overseen by the LPT Deteriorating patient and Resuscitation Group. The purpose of monitoring is to provide assurance that the agreed approach as set out in this policy in relation to ReSPECT is being followed – this ensures we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
5.6c	Completion of LPT ReSPECT audit form		ReSPECT Audit CYPACP	Deteriorating Patient and Resus Group The Child Death overview panel (CDOP) process requires the audit of CYPACP	Annual

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

NHS Leicestershire Partnership NHS Trust

Self-Assessment Form

Resuscitation and Escalation Competencies

Full Name of Professional:-	Surname:		Forename	
Clinical Setting where Professional employed:				
Competency	Professional to self-assess by ticking box inc date if they feel fully competent	Reflection/ Discussion with Manager:	Action Plan (if required)	Manager's signature on completion of Action Plan and Date:
Advanced Communication Skills				
Supports patients and families through uncertainty using knowledge of the impact of disease and its treatments to discuss care options and coping strategies				
Demonstrates respect, compassion, sensitivity and a non-judgemental attitude				
Recognises and takes the opportunity by picking up on cues to hold deeper discussions relating to psychological, emotional or spiritual issues				

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

demonstrating higher level communication skills				

Advanced Communication Skills				
Analyses complex patient situations and shares experiences and insights with others				
Demonstrates an ability to ask potentially difficult questions and sensitively communicates 'bad' news or possible contentious information or decisions				
Able to effectively liaise and work collaboratively with multi-professional staff working across all providers of care				
Knowledge and Skills				
Educated to degree level or equivalent				
Can provide evidence of continued professional updating including attendance at mandatory training				
A recognition of patterns of disease progression, likely outcomes and disease trajectory				
and the use of these to initiate timely EOL discussions and decision making				

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

Can evidence awareness of the following laws, policies and best practice to guide their decision making processes: Current Law around DNA-CPR Policies and the processes set out in the: · NMC Code of Professional Practice · Mental Capacity Act (2005) · Safeguarding adults · Advanced decisions to refuse treatment (ADRT) · Advanced Care Plans · Human Rights Act (1998) · Equality Act (2010) · EOL Care Strategy(2010).				
Higher Level Decision Making				
Is able to critically assess, analyse and interpret complex: • Clinical situations • Best Interest Decisions				
Anticipates and recognises the changing clinical status of a deteriorating patient and weigh the risks/benefits of investigations and treatments including CPR				
Works with patients in shared decision-making around treatment options within the principles of consent and best interest				

Leicestershire Partnership NHS Trust (LPT) Specific Addendum

Applies professional judgement to make decisions and achieve appropriate care outcomes				
Records in accurate, detailed, and contemporaneous manner, the rationale for complex decisions including best interest decisions				
Demonstrates awareness of own limitations, prejudices and accountability, through reflective practice and clinical supervision				
Organisational Skills				
Understands and adheres to the need for working within the scope of policies, procedures and guidelines				
Able to work within a team and independently in complex situations e.g. working with patients, and liaison across organisational boundaries				
Identifies and manages poor practice by escalating any clinical risks to line manager.				
Uses leadership, supervisory and facilitation skills to communicate changes in patient treatment plans to all care providers				
Be able to demonstrate the ability to complete accurate, detailed and contemporaneous records in line with LPT Policy				

University Hospitals of Leicester (Specific Addendum)

ROLES – WHO DOES WHAT

1.1 Chief Executive

- The Chief Executive has overall responsibility for Trust compliance with this Policy and Procedures

1.2 Medical Director

- The Medical Director is responsible for making arrangements to support the safe and effective implementation, monitoring and review of this policy. This is delegated to the Chair of the UHL Resuscitation Committee.

1.3 Chairs of the Resuscitation Committee

The Resuscitation Committee Chairs, supported by members of the Committee, and the UHL Senior Resuscitation Officer, is responsible for:

- Continuing to develop this policy
- Consideration of educational needs
- Monitoring compliance with this policy and completion of ReSPECT and DNACPR forms
- Review of this policy and identifying the appropriate reviewer(s).

1.4 The Resuscitation Committee

- The Resuscitation Committee, meeting as a minimum quarterly, acts as a decision-making body for development and implementation of operational policies relating to ReSPECT and DNACPR.

1.5 Senior Resuscitation Officer for UHL and LLR alliance

- In addition to supporting the Resuscitation Committee Chair with 4.3, the Senior Resuscitation Officer has a responsibility for co-ordinating educational programmes relating to Resuscitation and ReSPECT & DNACPR decisions.

1.6 Clinical Management Group (CMG) Directors / Leads and Heads of Nursing

are responsible for:

- Making sure that all staff in their CMG are made aware of the policy and procedure for completion of an ReSPECT and DNACPR forms.
- Making sure that staff groups and individuals complete training appropriate to their role
- Managing the effectiveness of this policy through a robust system of reporting, investigating and recording incidents and report any concerns / issues to the CMG Quality and Safety Boards.
- Ensuring process are in place to undertake audits of compliance, results reviewed and actions taken to address any areas of non-compliance
- Act on the results of Audits pertaining to resuscitation

1.7 Ward Managers, Heads of Service of all services in UHL /LLR Alliance are responsible for ensuring:

- Staff and trainees are aware of the UHL DNACPR policy and the ReSPECT and DNACPR forms
- Staff and trainees have had the opportunity to attend the appropriate level of training as part of their contract of employment.
- Review of audit results and actions taken where applicable.

University Hospitals of Leicester (Specific Addendum)

1.8 Consultants and Associate specialists are responsible for ensuring

- That ReSPECT and DNACPR decisions are considered as part of overall patient care in a timely way and form part of the consultant ward round as part of escalation planning.
- ReSPECT and DNACPR decisions are considered, dependent upon a patient's individual circumstances and goals ReSPECT and DNACPR discussions with patients and relatives/carers are undertaken in line with this policy and documented accordingly in the patients' records.
- The ReSPECT and DNACPR form is correctly completed the form filed at the front of the patient's medical notes and decision reviewed, as appropriate
- Effective communication of a ReSPECT and DNACPR decision to the rest of the clinical team and when the patient's care is transferred (both internally and externally)
- That delegated decision making, associated discussions and records are in accordance with this policy.
- That ReSPECT and DNACPR forms are endorsed at the next ward round or earliest opportunity but no later than 5 days from the date of the decision

1.9 UHL Doctors at Middle Grade Level, an Advanced Clinical Practitioner or other registered healthcare professional with the appropriate competence, training and experience
are responsible for ensuring:

- ReSPECT and DNACPR decisions are considered, dependent upon a patient's individual circumstances and goals
- ReSPECT and DNACPR discussions with patients and relatives/ carers are undertaken in line with this policy and documented accordingly in the patients' records.
- The ReSPECT and DNACPR form is correctly completed the form filed at the front of the patients medical notes and decision reviewed, as appropriate
- Effective communication of a ReSPECT and DNACPR decision to the rest of the clinical team and when the patient's care is transferred (both internally andexternally)
- Any ReSPECT and DNACPR decisions not made by either a Consultant or Associate Specialist are endorsed at the next ward round or earliest opportunity but no later than 5 days from the date of the decision. This might involve consulting with the on call consultant out of hours.

1.10 All Clinical Staff involved in the care of patients in UHL & Alliance
are responsible for:

- Adhering to this policy and supporting procedures
- Notifying their line manager of any training needs and for undertaking relevant training
- Ensuring they are aware of the existence of a ReSPECT and DNACPR decision
- Checking the validity of a ReSPECT and DNACPR form and escalating concerns appropriately

University Hospitals of Leicester (Specific Addendum)

- That the ReSPECT and DNACPR decision is communicated as part of ALL clinical handovers and ensure updating of any electronic systems.
- Notifying other services of the ReSPECT and DNACPR decision on the transfer of the patient – both internally and externally
- Participating in the audit process and acting on the results accordingly.
- Understanding the relationship between the Mental Capacity Act (2005) and the Human Rights Act (1998) relating to ReSPECT and DNACPR decisions

2. Unexpected deterioration and cardiac arrest

2.1. 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.

2.2. 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:

2.2.1. 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.

2.2.2. 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)?

2.3. Within UHL a Doctors at Middle Grade Level, an Advanced Clinical Practitioner or other registered healthcare professional with the appropriate competence, training and experience can initiate the completion of a ReSPECT form which must be countersigned by the senior clinician responsible for the care of the patient at the next ward round or earliest opportunity but no later than 5 days from the date of admission

2.4. When a patient is admitted or transferred into the Trust, who has a documented a valid ReSPECT form or a valid DNACPR only form there is no need to complete a new form, but the admitting medical team should review the decision at the next ward round or earliest opportunity but no later than 5 days from the date of admission. Existence of the DNACPR form and its origin should be documented in the patient's contemporaneous notes and the form filed at the front of the patients notes.

2.5. When an 'out of area' patient is admitted to UHL who has a documented DNACPR decision from a different healthcare setting, this DNACPR form will be considered valid by the Trust

as long as it has an original signature and is dated.(subject to Section I) It is essential that the admitting medical team review the DNACPR decision at the next ward round or earliest opportunity but no later than 5 days from the date of admission. If the decision remains valid this should be documented on the East Midlands DNACPR form and in the contemporaneous notes.

2.6. Where a patient has a photocopy of their ReSPECT form or a valid DNACPR only form this should be reviewed and re-written as soon as possible. Should the patient experience Cardio-pulmonary arrest whilst this is pending, the photocopy should be considered valid as long as it correctly identifies the patient, and has not exceeded its review date

2.7. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought from the Head of Legal Services

2.8. For Children and Young People Advanced Care Planning / ReSPECT documentation please refer to UHL policy “Decisions relating to Cardiopulmonary Resuscitation (including the use of Advanced Care Plans (ACP) and Do Not Attempt CardiopulmonaryResuscitation (DNACPR) orders : Policy for Infants, Children and Young People aged less than 16 years.

2.9. Patient Leaflets

A range of patient leaflets will be available from the Patient information librarian.

- Patients Guide – Respect and you : planning together
- Patients Leaflet – Respect what happens now
- Patients Guide for young people
- Parent Guide
- Easy read leaflet

References

- Advance Decision to Refuse Treatment, a guide for health and social care professionals.
  London: Department of Health.

- British Medical Association, (2000). The impact of the Human RightsAct 1998 on medical decision-making. London, BMA Books.

- British Medical Association, (2001). Withholding or withdrawing life-prolonging medical treatment. 2nd ed. London, BMABooks.

- 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_1
  9980042_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.

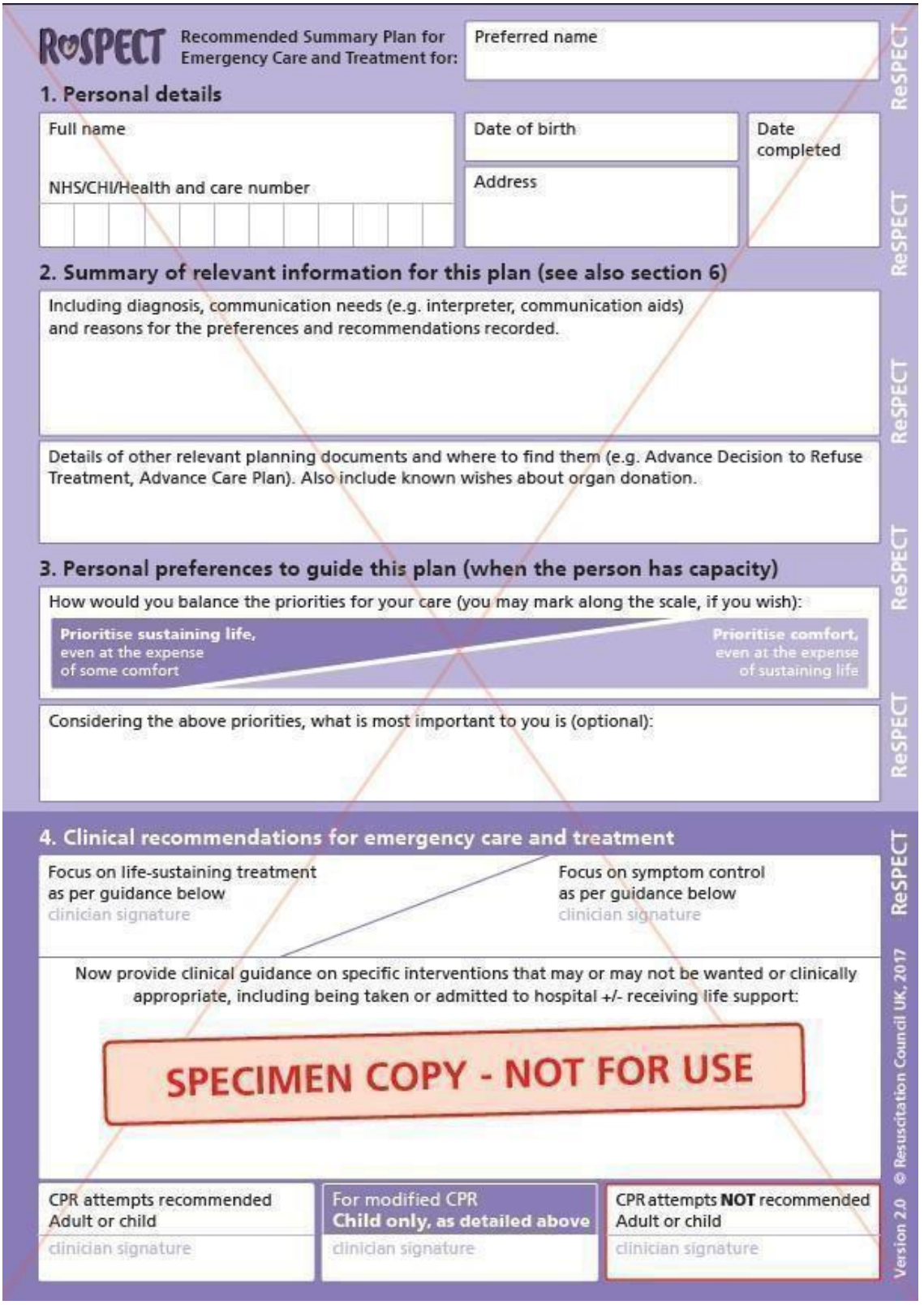
- Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)Adult Policy NHS South Central 2010.

- Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB)

List of Appendices

Appendix No	Title
Appendix 1	**Respect Form**
Appendix 2	**Decision making framework for CPR**
Appendix 3	**Quick Guide For Clinicians**

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	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

ReSPECT

Version 2.0 © Resuscitation Council UK, 2017

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

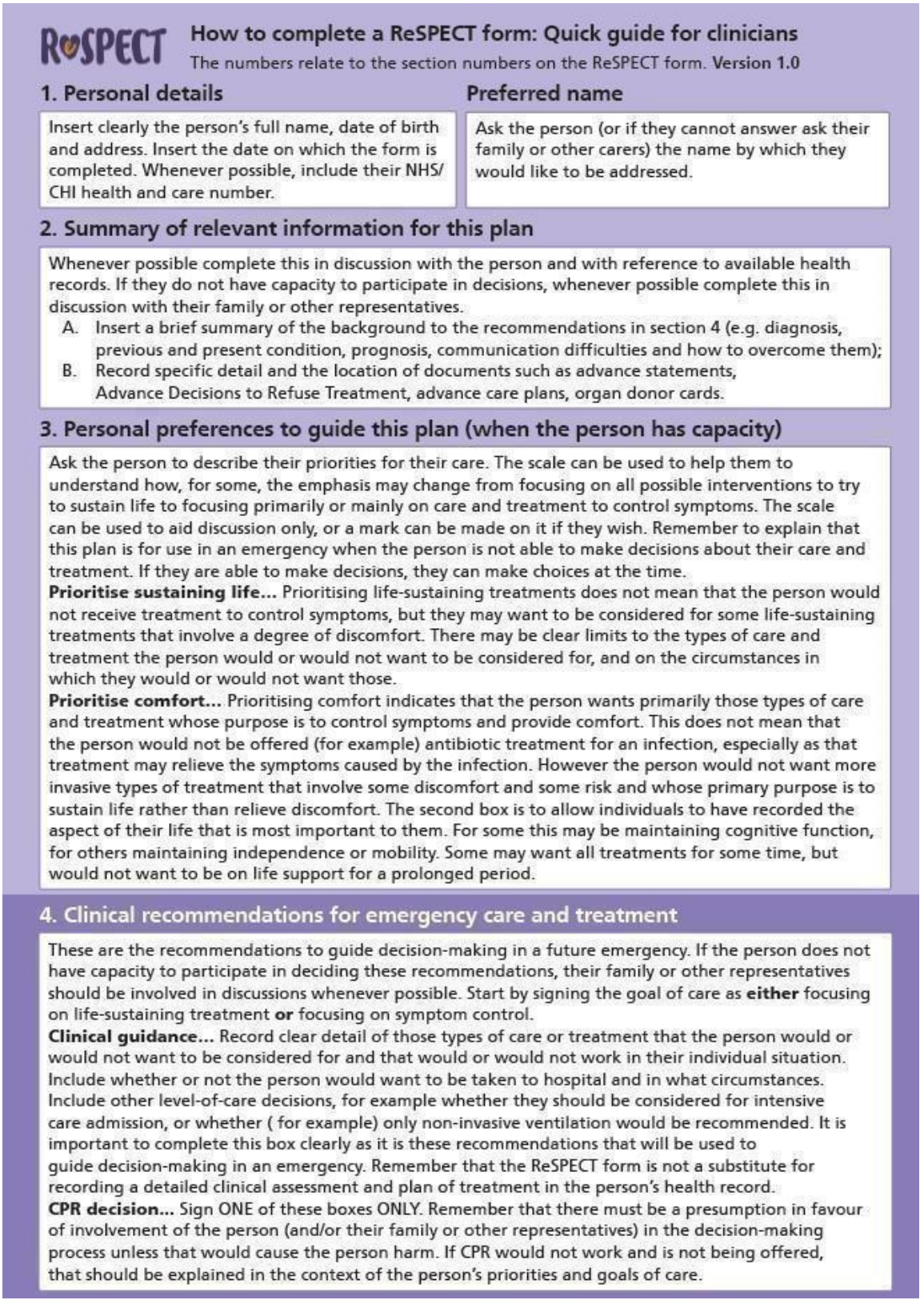
8. Emergency contacts

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



ReSPECT

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.

Leicester, Leicestershire and Rutland (LLR) Working in Partnership Across Services

APPENDIX 3

Decision-making framework for CPR