Staffordshire and Stoke-on-Trent
Integrated Care System

Policy Document

ReSPECT Integrated Care System Policy

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Version Control Schedule

Version	Issue Date	Comments
1	19/03/24	This Policy has been developed to support providers in aligning their ReSPECT Policy's in such a way to promote standardised best practice and to facilitate the effective and safe movement of individuals into a cross Staffordshire and Stoke on Trent.

1.1	10/05/24	Amendments made after the ICB Quality & Safety Committee 10/04/24. 1. Decisions to limit treatment must be discussed with the individual to whom the recommendations apply unless to do so would cause harm. Legally there needs to be convincing reasons not to involve the patient and it should only be taken if it leads the person to suffer physical or psychological harm (tracey-approved.pdf (judiciary.uk). Such decisions should also be discussed with those close to the person dependent on consent and capacity. 2. The frequency of review should be determined by the health professional in charge of the person's care and will be influenced by the clinical circumstances of the person, for example if a patients capacity changes after a ReSPECT plan is completed it must be reviewed. 3. A paper copy of the ReSPECT plan should be used; this can be printed but should be the original copy, not a photocopy and should have a signature which makes it specific to the author. The document should ideally be printed in colour to aid identification. Documents printed in black and white are acceptable if no other option is available if it can be reasonably assured that it is an original document with a signature that makes it specific to the author. 4. All ReSPECT planning should be in line with the Mental Capacity Act (2005)

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1. INTRODUCTION

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. It is a widely used process and is recognised nationally. People in Staffordshire will be able to transition from one care setting to another with all health and social care professionals recognising and endorsing ReSPECT plans. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency, including cardiac arrest, in which they do not have capacity to make or express choices. The process is intended to respect both individual preferences and clinical judgement. The agreed clinical recommendations that are recorded should include a recommendation on whether CPR should be attempted if the person's heart and breathing stop. ReSPECT aims to promote more conversations between people (and / their families / carers) with clinicians, leading to shared decision making (when possible), better advance planning, good communication and documentation and better overall care.

The aims of the ReSPECT System Policy are:

- To set out the principles which govern the use of the Recommended Summary Plans for Emergency Care and Treatment (ReSPECT).
- To ensure that any decisions relating to a person's care and treatment, including Do Not Attempt CPR, are made with the person, or their representative, and are appropriate to the circumstance and include any limitations, with reference to.

2. SCOPE

- This policy applies to all health and social care professionals working within Staffordshire and Stoke on Trent Integrated Care System.
- This policy applies to all adults in whom advance recommendations relating to healthcare are being considered. This includes those at risk of deterioration or cardiac arrest, or those who want to have their wishes documented. A conversation regarding treatment options and focus of care should be held and a ReSPECT plan summarising the plan completed.
- The aim of the ReSPECT process is to protect individuals and support health and social care professionals in making complex recommendations to ensure all decisions/discussions are clearly recorded.
- Providers are at liberty to adopt this Policy for use by their own organisation, but if individual Providers devise their own policies, it is expected that they will reflect the principles outlined herein.
- This policy has been written with reference to the latest guidance issued by the British Medical Association (BMA) / Royal College Nursing (RCN) / Resuscitation Council and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society, and the Resuscitation Council (UK) and NHSE/I.

3. DEFINITIONS

- Advance decision making about care and medical treatment involves collaboration between a person and healthcare / social care professionals.

- In an emergency, it is vital that healthcare professionals have a clear understanding of any identified limitations in an individual's treatment (such as to withhold cardiopulmonary resuscitation.
- A ReSPECT plan acts as a summary document for any key information that could influence emergency care at a time when a patient may not be able to express their wishes. This policy refers to decisions about a range of emergency care and treatment options. Such life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, and admission to intensive care unit (ICU) for intubation and ventilator support, inotropic and other cardiovascular support, as well as cardiopulmonary resuscitation (CPR).
- All significant treatment limitations must be clearly recorded on the ReSPECT plan. This could include preferences about Critical Care admission, drug, or other treatments – it is not limited to resuscitation decisions.
- Any recommendations made should be useful and supportive of decision making in an emergency.
- Treatments or approaches that are recommended can also be recorded on the ReSPECT plan. This could include preferences related to specific intervention that have proven to work previously or alternatives to treatment limitations that have also been recorded on the ReSPECT plan.
- ReSPECT is not a legally binding document. The ReSPECT plan should be regarded as a summary of an advance clinical assessment with recommendations recorded to guide immediate clinical decision-making in the event of a person's physical health deterioration. The final decision regarding whether to attempt CPR or other life-sustaining treatment rests with the healthcare professionals responsible for the person's immediate care at the point of deterioration.
- A ReSPECT plan does not replace additional detailed advance care planning documentation, such as Advance Decision to Refuse Treatment (ADRT) documents.
- All ReSPECT plans should be completed using the Universal Principles for Advance Care Planning (2022).
- All ReSPECT planning should be in line with the Mental Capacity Act (2005).
- Decisions to limit treatment must be discussed with the individual to whom the recommendations apply unless to do so would cause harm. Legally there needs to be convincing reasons not to involve the patient and it should only be taken if it leads the person to suffer physical or psychological harm (tracey-approved.pdf (judiciary.uk)). Such decisions should also be discussed with those close to the person dependent on consent and capacity.
- A paper copy of the ReSPECT plan should be used; this can be printed but Healthcare providers, who are uncertain about the need to give life-saving care, should always presume to save life. Emergency care should be given until any previously agreed limitations are clearly understood – this clarity is the purpose of the ReSPECT plan. • ReSPECT plans should be considered for review when a person's condition or wishes significantly changes, or when they are transferred / admitted / discharged from one healthcare provider to another.
- A paper copy of the ReSPECT plan must stay with the individual so that health and social care staff can easily access them.
- The frequency of review should be determined by the health professional in charge of the person's care and will be influenced by the clinical circumstances of the person, for example if a patients capacity changes after a ReSPECT plan is completed it must be reviewed. The aim is to maintain the document as a valid and appropriate set of recommendations to support decision making in an emergency, all questions about checking and reviewing the document should be considered with this in mind.

- It is the responsibility of all health and social care professionals to be aware of the existence and the location of any ReSPECT or any other type of advance care plan.
- It is their responsibility to ensure that it appears to remain valid, appropriate, and useful to the care of the individual with whom it is written.
- If it is not valid, appropriate, and useful then to review the document themselves if they have decision-making responsibility or to flag it to an appropriate decision maker for review.
- The safest approach to a ReSPECT plan is to make no assumptions about what it says, the priority being to read and understand the document.
- It must not be assumed that a ReSPECT plan implies that a person is for a palliative approach or is end of life, nor should it be assumed that CPR is not recommended.

Advance Care Plan (ACP)

Advance Care planning is a voluntary process of person-centred discussion between an individual and their care providers about their preferences and priorities for their future care, while they have the mental capacity for meaningful conversation about these. The process, which is likely to involve several conversations over time, must have due consideration and respect for the person's wishes and emotions at all times. As a result, the person should experience a greater sense of involvement and the opportunity to reflect and share what matters most to them.

The outputs of these discussions may include one or more of the following:

- An advance statement – of wishes, preferences, and priorities, and may include nomination of a named spokesperson
- An Advance Decision to Refuse Treatment (ADRT)
- Nomination of a Lasting Power of Attorney (LPA) for health and welfare who is legally empowered to make decisions up to, or including, life sustaining treatment on behalf of the person if they do not have mental capacity at the time, depending on the level of authority granted by the person.
- Context-specific treatment recommendations such as emergency care and treatment plans, treatment escalation plans, cardiopulmonary resuscitation decisions, etc. This would include a ReSPECT document.
- Important considerations
- ACP must always be a voluntary process. People may have different level of preparedness to consider the implications of advance care planning. They may or may not be ready to have these conversations and must not feel forced or rushed into this, nor denied the opportunity of these discussions in the future.
- The basic premise of ACP is that the person has the mental capacity to engage in the discussion at the time and fully understands any decision they choose to make about their future care. This is especially the case if the outcome of the discussion includes ADRT or the nomination of LPAs.
- Nobody should be treated as unable to make a specific decision unless all practical efforts have been made to help them to do so.
- However, even if somebody does not have sufficient capacity to fully participate in ACP, they may still be able to express personal views and preferences, which should inform plans for their care as they approach the end of their lives.
- Those who are important to the person, including their carers and family, must be consulted and their views properly considered. In these situations, clinician-led discussions about treatment escalation and other measures of anticipatory clinical management planning for urgent situations that may arise should be undertaken with the person's LPA if they have one, advocates and those important to them, based on best interest's decision

making in line with the Mental Capacity Act. Universal Principles for Advance Care Planning.

In March 2022, the NHS published "Universal Principles of Advance Care Planning (ACP) which set out six high level principles for Advance Care Planning in England:

1. The person is central to developing and agreeing their advance care plan including deciding whom else should be involved in the process.
2. The person has personalised conversations about their future care focused on what matters to them and their needs.
3. The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals.
4. The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.
5. The person has the opportunity, and is encouraged, to review and revise their advance care plan.
6. Anyone involved in advance care planning can speak up if they feel that these universal principles are not being followed.

a) ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. It is a widely used process and is recognised nationally. People in Staffordshire will be able to transition from one care setting to another with all health and social care professionals recognising and endorsing ReSPECT plans.

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

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

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

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

f) The primary goal of healthcare is to benefit people, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the person, or if an adult with capacity has refused treatment, and documented accordingly, when necessary, then that treatment is no longer justified (BMA, RC (UK) RCN 2007). Even potentially

lifesaving treatment can be withheld or withdrawn if it is not in the person's best interests, and they lack capacity to make that decision at that time.

g) Cardiopulmonary resuscitation (CPR) is one treatment that has received much attention, and that has undoubted potential benefits for some people. However, CPR is often physically damaging (e.g., breaking ribs) and for many people there will be minimal or no chance of success, offering little or no benefit to the person receiving it. A person may make an informed decision that they do not wish to receive attempted CPR should they suffer cardiorespiratory arrest, even if it might have a good chance of success in their situation.

h) Evidence suggests that when discussions have taken place about CPR in the context of overall goals of care there is a reduction in the incidences of harm compared with focusing only on 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions and where harm does occur it is less severe.

i) Recommendations about whether these treatments should or should not be given to a person are often referred to as 'emergency treatment plans' or 'treatment escalation plans. They concern recommendations about the appropriateness for everyone of starting or not starting, continuing, or not continuing, certain treatments. These treatments may include, for example, clinically assisted hydration or nutrition, assisted ventilation, or intravenous antibiotic therapy.

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

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

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

m) Decisions documented on a ReSPECT plan do not override clinical judgement. In the event of a reversible cause of the person's deterioration that does not match the circumstances envisaged when those decisions were made and recorded then the

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

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

What is a ReSPECT conversation?

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

A ReSPECT conversation follows the ReSPECT process by:

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

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

Advance decisions must be made based on an individual patient assessment and in consultation with the person, save in the exceptional circumstance that consultation is likely to cause physical or psychological harm to that person. The reason(s) not to consult with the person must be recorded in the patient record.
ReSPECT may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, an education setting, a hospice, or a hospital. Professionals such as ambulance crews, out-of-hours health care professionals, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to an agreed plan and clinical recommendations on a ReSPECT plan.

To whom does this policy apply?

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

b) This policy is intended for all adults, below is a list (although not exhaustive) where a ReSPECT conversation and plan may have more relevance.

   1. An individual with particular health needs that may involve a sudden physical deterioration in their health which needs to be planned for.
   2. An individual with a life limiting condition, such as advanced organ failure, advanced cancer, or frailty.
   3. An individual who is likely to be nearing the end of their life.
   4. An individual at risk of sudden events, such as epilepsy or diabetic crisis.
   5. An individual at foreseeable risk of death or sudden cardiorespiratory arrest.
   6. An individual who wants to complete the ReSPECT process and documentation for other reasons.

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

d) If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with the person for whom the ReSPECT plan is being completed. However, they may still wish to discuss other aspects of emergency care and treatment, so then a ReSPECT conversation may be appropriate.

e) This policy refers to decisions about a range of emergency care and treatment options. Such life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, and admission to an intensive care unit (ICU) for intubation and ventilator support, inotropic and other cardiovascular support, as well as CPR. This process may include recommendations to carry out interventions well as to not carry out interventions.

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

Cardiopulmonary resuscitation (CPR)

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

about CPR in the context of broader plans for emergency care and treatment, and to record the resulting recommendations on a form that would be used and recognized by health and care professionals across the UK.

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

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

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

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

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

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

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

i) DNACPR recommendations will no longer be recorded on separate documentation including the DNACPR form; recommendation will be recorded on a ReSPECT plan only as anticipatory recommendations about CPR are best made in the wider context of advance care planning.

This is an important part of good quality care for any person who is approaching end of life and/or is at risk of cardiopulmonary arrest.

j) Existing and valid DNACPR decisions recorded on DNACPR documentation can still be used as long as they remain valid and appropriate). There is no need to actively change pre-existing forms as a matter of course unless clinically indicated or due review. The old DNACPR form must then be cancelled but should refer to the now completed ReSPECT plan to avoid confusion as to the person's DNACPR status and filed in the patient health record. This same principle applies to older versions of the ReSPECT forms, so long as it is valid and appropriate to the individual it is acceptable to use it, although it may be appropriate to consider a nonurgent request for the form to be transferred to the current version.

k) All DNACPR decisions are to be recorded on a ReSPECT plan as part of a ReSPECT conversation.

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

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

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

o) If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and that CPR or other life-sustaining treatment would not be effective, CPR should not be attempted. Detailed arrangements about how this should be managed should be included in Providers own Policy's.

p) The Parliamentary and Health Service Ombudsman published guidance on DNACPR in 2024, they found that;

1. People are not told as a matter of course (as is legally required) that a DNACPR decision has been made. This causes distress and affects people's trust in the NHS and doctors.
2. Conversations about end-of-life are often held too late. Acute settings and A&E are not the best places for sensitive and thorough conversations, but this is where most conversations happen. Simple changes to common practice in the health service could support these conversations taking place before emergency settings.
3. When DNACPR decisions are left too late, it often leaves conversations to the patient's family, leaving the patient out of the conversation entirely. This causes distress to families or carers and can leave people with a sense of injustice, leading to complaints to us.
4. There is a lack of accessible information given at the time or before DNACPR conversations take place.
5. There are issues with record-keeping and documenting decisions. Correct and up-to-date

6. DNACPR decisions do not follow a patient throughout the medical system. While a DNACPR decision should be logged on patient records, this cannot be accessed across the whole health system and there are often problems with advance decisions being logged, updated and respected.
7. People voiced genuine fears about ageist and ableist attitudes and behaviours in the NHS.
8. The public are often unaware of who is responsible for making a DNACPR decision and what treatment it covers. This leads to frustration and distress when people believe it is their decision and not a clinical decision.

ReSPECT plans in practice

a) Every decision about emergency care and treatment options must be made based on a careful assessment of everyone's situation and wishes.

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

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

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

e) During such discussions, staff should explore treatment options and goals of care (e.g., referral to ICU, HDU, antibiotics and NEWS scoring etc.) which are relevant to the individual. Recommendations limiting other aspects of care must be clearly and explicitly recorded in the medical record and communicated to the multi- disciplinary team. These conversations must reflect the needs of the patient across all potential settings as much as possible, recording "forward-based treatment" when a patient is about to be discharged home for example would render it potentially useless.

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

g) For non-English speaking individuals and families, to ensure an informed decision can be arrived at, an interpreter will be required. It is not good practice to use relatives as interpreters. To obtain interpreters follow local procedures. All ReSPECT plans should be written in English to ensure they are useable by health and social care professionals in an emergency. It is also entirely appropriate to consider obtaining a translated copy of the plan into a form that helps the patient's understanding.

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

i) This Policy enshrines the belief that everyone stands to benefit when we embrace and value the diversity of thoughts, ideas, and ways of living that people from different backgrounds, experiences and identities bring. This applies to Advance Care Planning particularly and all health and social care professionals must be open to and mindful of this diversity in the way they approach these conversations, any assumptions they bring with them, how they communicate and with whom.

j) ReSPECT recommendations should be recorded on the nationally recognised paper form, which should be kept in an accessible location to support timely accessibility and person centred care. When an individual is an inpatient, the ReSPECT plan should be kept in a paper form at the front their medical record. When the person is not an inpatient the individual should be encourages to keep the written plan at the front of any community records. If the individual does not wish to keep it in the recommended location, then the actual location should be clearly recorded at the front of any patient held record to allow accessibility for all.

k) All sections of the form should be completed, and an entry should be made in the healthcare records providing the rationale for the decision by documenting all relevant discussions held with the individual and any relevant others.

l) A digital copy of the ReSPECT plan should be completed on One Health & Care, or a copy of the paper form uploaded onto the system. A signed print out of this plan digital plan must be provided to and always kept with the patient.

m) A paper copy of any ReSPECT plans must remain with the person.

Process for completing a ReSPECT plan.

A Doctor or an appropriate Advanced Clinical Practitioner undertakes a ReSPECT conversation with the person.

Is a digital plan possible?

- If it is then the plan should be completed in One Health and Care using the clinical system appropriate to the individual competing it i.e., EMIS, System One, I portal RiO etc.
- A copy should then be printed out, signed, and dated in black ink if possible.
- The copy should be then provided to the individual with guidance on where to keep it and how to use it.

If a digital plan is not possible.

- Complete a written ReSPECT plan using a nationally recognised ReSPECT plan.
- Ensure it is signed and dated.
- Scan/photograph the paper plan and upload it onto One Health and Care using the clinical system appropriate to the individual competing it i.e., EMIS, System One, I portal RiO etc.
- The original paper ReSPECT plan should be provided to the individual with guidance on where to keep it and how to use it.

Cancellation of emergency care and treatment decisions

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

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

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

d) If the document is cancelled and no replacement document is written or a new more up to date document is written, it is the author's responsibility to ensure all reasonable steps are made to upload these changes to any clinical systems that it may be recorded on.

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

Temporary suspension of emergency care and treatment decisions

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

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

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

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

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

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

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

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

The individual's right to life (article 2)

To be free from inhuman or degrading treatment (article 3)

Respect for privacy and family life (article 8)

Freedom of expression, which includes the right to hold opinions and receive information (Article 10)

To be free from discriminatory practices in respect to those rights (article 14)

b) 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.

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

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

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

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

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

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

i) In situations where a person lacks capacity and staff are unaware that a valid advance decision refusing CPR (which is relevant to their current condition) has been made, then a further check must be made to identify if the individual has appointed a Lasting Power of

Attorney (LPA) for Health and Welfare or Court Appointed Deputy. Court Appointed Deputies have similar powers to those with Power of Attorney but are appointed for people who have never had capacity or have lost capacity before appointing an LPA.

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

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

4. ROLES AND RESPONSIBILITIES

- ReSPECT plans should only be written and reviewed by senior health care professionals such as GP's or medical consultants. Individual organisations may allow specially trained health care professionals including junior doctors, senior nurses, and other allied health care professionals to complete plans; a process that supports this would be laid out in the policies and procedures of individual providers. It assumes as an appropriate professional registration allied with the education, experience, and responsibility to make treatment related recommendations.
- It is the responsibility of the clinician completing the ReSPECT plan to inform the most senior registered healthcare professional in charge of a person's care (if it is not them) of its existence and contents in as timely a way as circumstances allow to ensure they are aware and can participate and influence decision making. This includes if the person is being transferred to a new environment where a different senor health care professional has responsibility.
- Ultimate responsibility for the completion or review of ReSPECT plans sits with the senior Doctor responsible for the patients care in their current location.

5. MONITORING AND REVIEW ARRANGEMENTS

- It is the responsibility of all staff to check for the presence of a ReSPECT document, to read it and to understand the recommendations contained therein. If any of the information or recommendation on the form appears incorrect or inappropriate to patient's current situation this should be flagged immediately for a review by the most appropriate senior professional i.e., Consultant, GP, or ACP.
- Individual providers may wish to upload ReSPECT documents to their clinical systems, but the understanding is that the paper copy with the patient should be referred to as the primary plan.
- Avoid copying ReSPECT plan where possible and only use this for filing purposes. When copies are required, they need to be clearly marked "COPY". If greeted with two forms, use the information on the most recent form.
- ReSPECT should be reviewed regularly. A review will be required:

- Whenever significant changes occur in the person's condition.
- If there is a change in the person's expressed wishes.
- Whenever the person is admitted, discharged, transferred from one healthcare provider to another or moved on or off a caseload.
- If the document is no longer valid, appropriate, or useful in recommending actions that should be taken in an emergency.

- The outcome of the review may be that no changes are required; this can be recorded using Box 9 on the ReSPECT plan.
- If a ReSPECT plan requires altering, a new ReSPECT plan should be written.
- The frequency of review should be determined by the health professional in charge of the person's care and will be influenced by the clinical circumstances of the person. The aim is to maintain the document as a valid, appropriate, and useful set of recommendations to support decision making in an emergency, all questions about checking and reviewing the document should be considered with this in mind.
- ReSPECT plans use covers hospital and community care episodes, including all health and social care professionals within Staffordshire.
- Following a 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 plan should be used and accepted by all providers across Staffordshire.
- It is possible that a person may have a DNACPR decision or another emergency care, and treatment plan documented on a different form. For example, they may have been transferred from a different ICS, an old version of the DNACPR plan may have been used, or their DNACPR decision may have been documented in an Advance Decision to Refuse Treatment without an accompanying ReSPECT plan.
- Unless there is a good reason to believe the decisions are not genuine or applicable, they should be accepted as valid until the decisions are reviewed by the person's responsible senior clinician, a ReSPECT conversation takes place, and a ReSPECT plan completed. This conversation should be treated as a priority to avoid aby confusion which may lead to harm.
- If an original ReSPECT plan is not available, it is not acceptable to use a photocopy due to the risk of older invalid documents being used when a more recent form may be in acceptance.
- Once made, all recommendations must be communicated effectively to the relevant health professionals.
- It is imperative that anyone involved in advance care planning have the opportunity to speak up if they feel that the universal principles of ACP are not being followed. This should trigger an immediate review of the ReSPECT plan by the senior HCP responsible for the person.

6.1 Review

- The policy is to be reviewed on the 5th of September 2025