Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) policy

Regional Policy for North and North East Lincolnshire

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Northern Lincolnshire Policy on behalf of the following organisations:

NHS: Northern Lincolnshire & Goole NHS Foundation Trust

NHS: North Lincolnshire Clinical Commissioning Group

NHS: North East Lincolnshire Clinical Commissioning Group

Care Plus Group (CPG)

Lindsey Lodge Hospice

St Andrew's Hospice

NAViGO

RDASH

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1 DEFINITIONS

Healthcare Professional
A Registered Nurse (RN), Doctor or Allied Healthcare Professional (AHP).

Cardiopulmonary Resuscitation (CPR)
An emergency procedure that may involve the following actions in an attempt to restart the patient's heart and breathing:

- Chest compressions (external cardiac massage)
- Ventilation of the lungs
- Defibrillation

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
A clinical decision not to commence cardiopulmonary resuscitation.

Mental Capacity
The ability of an individual to make decisions regarding specific elements or treatments of their life.

Mental Incapacity
A person lacks sufficient capacity in relation to a matter if, at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain. This lack of capacity may be permanent or temporary.

Advanced Decisions to Refuse Treatment (ADRT)
An advance decision made by any person aged 18 years or over, whilst having mental capacity, to refuse specified medical treatment or intervention for a time in the future when they may lack the capacity to consent to or refuse that treatment.

Independent Mental Capacity Advocate (IMCA)
An independent advocate appointed to support vulnerable patients who lack mental capacity and have no one appropriate to act on their behalf. IMCAs can also become involved if staffs conclude that relatives/other carers may not be acting in a patient's best interests.

Lasting Power of Attorney (LPA)
A legal document whereby an individual (the donor) authorises another person to act on his behalf in the event that the donor should lose the capacity to make his own decisions. This authority can be in respect of decisions regarding health and welfare or property and financial affairs. In order to be valid, an LPA should be executed on the prescribed form and registered with the Office of the Public Guardian. If it applies to end of life decisions, then this must be clearly stated.

Patient's responsible Consultant
The Consultant currently in charge of the patient's care.

Relevant other
For the purpose of this policy, relevant others may include: spouses, partners, relatives, carers (who are not acting in a paid or professional capacity), representatives, advocates, people with

lasting power of attorney, IMCAs and court appointed deputies.

Primary Care
For the purposes of this policy, Primary Care includes all services and settings outside of an acute hospital and may include: Hospices, Nursing Homes, Residential Homes and community services such as district nursing teams.

Secondary Care
For the purposes of this policy, Secondary Care includes all services within an acute hospital setting.

2 INTRODUCTION

This policy is for all adult patients (over the age of 18) and is intended for use alongside the national Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form (see Appendix 1 for sample version). It is envisaged at a future time that the ReSPECT form may be adopted by Children Services and this policy will be updated at that time. This policy addresses issues relating to the planning of emergency care and treatment.

Agreement has been reached across all providers and commissioners in Northern Lincolnshire to have a single ReSPECT form and policy which includes policy regarding decisions about cardiopulmonary resuscitation. These organisations include Northern Lincolnshire & Goole NHS Foundation Trust, North Lincolnshire Clinical Commissioning Group, North East Lincolnshire Clinical Commissioning Group, Care Plus Group, Lindsey Lodge Hospice, St Andrew's Hospice, East Midlands Ambulance Service (EMAS), RDASH and NAViGO.

CPR could be attempted on any patient in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically, CPR could be used on every individual prior to death. It is essential to identify patients for whom cardiopulmonary arrest represents the terminal event in their illness, and for whom CPR is therefore inappropriate.

Similarly, other life-sustaining treatments may be futile for those dying of a terminal condition as they would not reverse the underlying cause of the decline. It may then be appropriate to consider making decisions to avoid CPR and other life-sustaining treatments, to ensure that if death occurs there is no added loss of dignity or increase in suffering.

It is also essential to identify those patients (who are deemed to have capacity to make the decision) who would not want such treatments to be attempted in the event of deterioration in their condition and who refuse these treatment options, even if it is clinically felt they may benefit from them.

Considering 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 patient who is approaching the end of life and/or is at risk of further deterioration and cardiopulmonary arrest.

ReSPECT is an approach to discussing, making and recording recommendations about future emergency care and treatment including, but not limited to, cardiopulmonary resuscitation (CPR). ReSPECT focuses on treatments to be considered, as well as those that are not wanted or would not work. Such life-sustaining treatment could include, but is not limited to admission to hospital, antibiotics either (intravenous or oral), fluid resuscitation, clinically assisted hydration or nutrition,

admission to an intensive care unit (ICU) for intubation and ventilator support/ inotropic and other cardiovascular support, as well as CPR.

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, patients may still wish to discuss other aspects of emergency care and treatment. Therefore a ReSPECT conversation should not be limited just to those who are approaching end of life, and thus remains an important consideration for (but not limited only to) those with significant frailty or chronic progressive long term conditions for whom prognosis could realistically be expected to be less than a year.

It is important to be aware that a patient can have a ReSPECT document and remain FOR CPR. It is crucial that a ReSPECT document is not confused with being a Do Not Attempt CPR (DNACPR) form/decision.

Where no explicit decisions about treatment and CPR have been considered and recorded in advance, there should be an initial presumption in favour of full escalation of treatment and CPR. However, in some circumstances where there is no recorded explicit decision (for example in a person in the advanced stages of a terminal illness where death is imminent and unavoidable, and CPR would not be successful) a carefully considered decision not to start CPR may be appropriate. More detail on these circumstances can be found in section 4 of this policy.

Some patients, whilst having capacity, may wish to make an Advance Decision or statement about treatment stating they would not wish to receive such treatments in some future circumstances. These wishes may be recorded in an Advanced Decision to Refuse Treatment (ADRT), or in an Advance Care Plan (ACP). In the event of them losing capacity these patients should be managed in accordance with their wishes.

Making decisions not to use certain treatments and/or attempt CPR that have no realistic prospects of success does not require the consent of the patient, or those close to the patient. However, **any decisions about treatment and/or CPR should always be communicated to the patient, and/ or their relevant others (subject to any confidentiality restrictions) except in the exceptional circumstance that consultation is likely to cause physical or psychological harm to either that patient/or the relevant others.** Informing the patient and relevant others of these decisions with a clear explanation will make the likelihood of potential conflicts of opinion very rare. However, should these decisions not be accepted by the patient or their relevant others, then the provision of a second opinion should be offered.

This policy has been adapted with permission from Doncaster and Bassetlaw Teaching hospitals and Lincolnshire 'ReSPECT document' policies which were 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) Decisions relating to cardiopulmonary resuscitation (2016).

It is also written with due regard for the requirements of the Mental Capacity Act MCA 2005. For greater detail and guidance related to the MCA and assessment of capacity, please refer to your respective organisations MCA policy.

This policy should also be read in conjunction with the relevant professional standards and guidelines including:

- The Nursing and Midwifery Council (NMC) publication: The Code: Professional standards of practice and behaviour for nurses and midwives (2015)
- The General Medical Council (GMC) publication: Treatment and care towards the end of life; good practice in decision making (July 2010)

3 PURPOSE

The purpose of this policy is to ensure that healthcare professionals are aware of their responsibilities in relation to ReSPECT recommendations (including CPR decisions) and processes and are fully supported in their role so patients receive appropriate care. In particular, the policy aims to achieve a coordinated approach across Northern Lincolnshire so that transfer of patients between services does not compromise their dignity, quality of care or their patient choice.

Specific objectives include:

- To ensure decisions regarding emergency care and treatment are made according to:
    - The clinical needs of the patient and assessment of whether treatments will be successful
    - The patient's wishes and best interests
    - Current ethical principles
    - Legislation such as the Human Rights Act (1998), Equality Act (2010) and Mental Capacity Act (2005)
    - Relevant court judgments
- To make emergency care and treatment recommendations transparent and open to examination and ensure patients, relevant others and staff have clear information about the process and their involvement
- To avoid inappropriate CPR attempts
- To ensure patients, relevant others and staff have clear information about the ReSPECT process and their involvement
- To encourage and facilitate open, appropriate and realistic discussions with patients and their relevant others about emergency care and treatment issues, including CPR, and to give guidance on good practice when having these discussions
- To ensure decisions are communicated to all relevant healthcare professionals and services involved in the patient's care
    - ReSPECT is appropriate for any adult – but with increasing relevance for those: with significant frailty or chronic progressive long-term conditions for whom prognosis could realistically be expected to be less than a year
    - Nearing the end of their life or at risk of cardiac arrest
    - Who want to record their preferences for any reason
- The ReSPECT form can generally be used to support discussions with patients and relevant others

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances, staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005). Key points are:

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory
- Any act done for, or any decision made on behalf, of a patient who lacks capacity must be done, or made, in that persons Best Interest.
- **There is no single legal definition of Best Interest.** Best Interest is determined on an individual basis and the starting point is the strong presumption that it is usually in a person's best interests to stay alive. From a legal standpoint, a recent Supreme Court judgment interpreted this statute for us and presented it in lay person's terms and stated that:

  '*in considering the best interests of this particular patient at this particular time, decision- makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be.' (Lady Hale)*

There is a framework in Appendix 3: 'Making CPR decisions when the patient lacks capacity' that gives further guidance.

For further detailed information or guidance please refer to your own organisations MCA policy.

4 DUTIES AND RESPONSIBILITIES

It is the responsibility of each individual organisation to ensure the implementation and circulation of this policy, and that healthcare professionals are also aware of this policy.

It is the responsibility of all healthcare professionals to familiarise themselves with this policy and apply its principles in clinical practice.

Compliance against this policy and the roll-out of the use of the ReSPECT documents will be monitored and audited by the ReSPECT implementation group and presented to relevant forums with the help of the ReSPECT document roll-out facilitator. Each individual organisation may still wish to monitor or audit the use of the ReSPECT document within their organisations beyond the scope of that group.

It is up to individual organisations to decide who they deem to be suitably qualified to complete a ReSPECT form (including CPR decisions) with a patient or relevant others (Appendix 2 shows a quick guide for clinicians on filling out the form appropriately).

The recommendation from the National and local ReSPECT implementation Groups is that this process should not be restricted to certain staff groups or grades, but that any healthcare

professional who has undergone appropriate training should be permitted to have a ReSPECT conversation with a relevant patient and complete the form, if they feel able to do so. To help organisations assess a health care professionals' competency, Appendix 5 shows an agreed list of competencies.

It is presumed that senior doctors will already have the competency to discuss and document DNACPR decisions through previous training (Specialist Training grade 3 (ST3) and above in hospital, and GP's within the community) and that their training needs prior to using the document will be based around the wider treatment escalation decisions and the practicalities of filling out the ReSPECT form (highlighted in the competency list in Appendix 5). If, however, an individual does not feel that they are competent with regards to making DNACPR decisions, they can then choose to have training that covers all of the competencies.

For all other doctors and health care staff they will need to have training that covers all of the competencies before being able to use the document.

It is possible that a particular healthcare professional will feel competent to complete a ReSPECT form (including CPR decision) for some patients but not others, depending on their own experience and competence i.e. a specialist respiratory nurse may feel competent to have a discussion with a patient whose underlying condition is COPD/pulmonary fibrosis, but conversely not for a patient with progressive cancer due a different level of understanding of the disease processes in the latter scenario.

The healthcare professional completing the form should fill in their details and sign the form. **The decision must then be discussed and agreed with the senior clinician responsible for the patient's care.** This might be their GP, Hospital/Hospice Consultant or out of hours practitioner depending on the setting/situation. **The name of the senior clinician that the decisions have been discussed with should be clearly documented and their agreement confirmed.**

Within Northern Lincolnshire and Goole NHS Foundation Trust, there is a requirement for the responsible consultant to review and endorse the form within 48 hours of the decision being made. They should countersign the form in the space provided. There is not a similar requirement for a GP to countersign the form in the primary care, given the logistical difficulties this might present for patients in the community setting, but where appropriate and feasible, the GP may wish in any case to countersign the form to further confirm their own agreement with the decision. There should however be a record on the document of the name of the GP with whom the decision, has been discussed and a record of this discussion should be entered in the patient's primary care electronic record.

In exceptional circumstances, a healthcare professional with appropriate training can initiate appropriate emergency discussions with the patient, and/or relevant others if the patient lacks capacity, with a view to making a ReSPECT decision (including CPR) without discussion or prior approval from the senior responsible clinician. For example, a dying patient in the community being attended by an unscheduled care practitioner, or a dying patient on an oncology ward with no senior doctor availability. In such circumstances the following criteria must be met:

- The patient must be in the final stages of a previously diagnosed chronic/terminal disease
- Death must be thought to be imminent
- CPR will not, in the judgement of the healthcare professional making the decision, be successful and will cause the patient a traumatic and undignified death

- Every reasonable effort to contact a senior doctor to assess the need for a CPR decision has failed

This interim decision must be reviewed at the earliest opportunity by a senior doctor responsible for the patient's care, and not later than 24 hours. Within a community setting this can include an out of hours GP.

5 PROCEDURE

5.1 General Principles

ReSPECT aims to promote more conversations between patients (and or relevant others) with Healthcare professionals, leading to shared decision making (when possible), better advanced care planning, good communication and documentation and better overall care.

ReSPECT addresses treatment planning in relation to emergency, potentially life-extending treatment and DNACPR. It should be considered for those patients who are at risk of a clinical deterioration that may place their life at risk. These patients may already have an existing life limiting illness, such as advanced organ failure or cancer.

The scope of ReSPECT can cover other treatments and decisions; for example, antimicrobial therapy in those at risk of infection, ventilation in those at risk of respiratory failure, or artificial nutrition/hydration in those at risk of aspiration. Additionally, individual patient wishes may lead to a ReSPECT document being considered, discussed and used, even in the absence of advanced or indeed any pre-existing illness.

ReSPECT recommendations must be made on the basis of an individual patient's assessment, and also in consultation with the patient, except in the exceptional circumstance that such consultation is likely to cause physical and/or psychological harm to that patient. Where the patient lacks capacity, their relevant others must be consulted.

At the time of completing a ReSPECT document, staff should discuss treatment options and goals of care which are relevant to the patient. Recommendations limiting aspects of care must be clearly and explicitly recorded in the medical notes and communicated to the multi-disciplinary team.

ReSPECT is not a legally binding document. It does not override clinical judgment in the event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged when the recommendation was made, provided that there is not a valid and applicable advance decision expressly refusing such intervention. **In an emergency, the presumption should be in favour of CPR if this has a realistic chance of prolonging life**. Examples for overriding ReSPECT in favour of treatment can include choking, blocked tracheostomy or cardiac arrest during an electric procedure. In the event of a patient undergoing general anaesthesia, the ReSPECT form should be acknowledged, reviewed and discussed with the patient and clinical team.

Where there is any uncertainty over a ReSPECT decision (particularly where it relates to CPR) then, in the event of a cardiac arrest, resuscitation should be commenced.

5.2 Resuscitation Decisions within ReSPECT documents

It is important to note a patient can have a ReSPECT document in place and be <u>for resuscitation</u>.

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

CPR could be attempted on any patient in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus, theoretically CPR could be used on every individual prior to death. It is essential to identify patients for whom cardiopulmonary arrest represents the terminal event in their illness, and for whom CPR is therefore inappropriate.

Similarly, other life-sustaining treatments may be futile for those dying of a terminal condition, as they would not reverse the underlying cause of the decline. It may then be appropriate to consider making decisions to avoid CPR and other life-sustaining treatments, to ensure that if death occurs there is no added loss of dignity or suffering.

It is also essential to identify patients, whilst they still retain capacity, who would not want certain treatments to be attempted in the event of deterioration in their condition, even if those treatments may provide some benefit. This is so that should they lose capacity their wishes can be known and followed.

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

DNACPR decisions are usually only appropriate in three settings:

- Where attempting CPR will not restore the patient's cardiac output, the healthcare team must be as certain as it can be that attempting CPR would be futile. This recommendation should be based on clinical assessment of the patient and relevant guidelines. In this scenario, patients/relevant others cannot insist that CPR is provided
- Burdens that outweigh benefits - where the expected benefit is outweighed by the perceived burden e.g. terminal illness. This assessment can only be made following discussion with the patient (and/or relevant others if the patient lacks capacity)
- or if the patient with capacity declines involvement but gives permission for their relevant others to be involved
- Patient refusal - where CPR is against the wishes of a patient it may be expressed verbally or in accordance with a valid and applicable ADRT. Guidance on what constitutes a valid ADRT should be found within your own organisation's MCA policy.

A decision-making framework relating to CPR, based on the "Resuscitation Council UK (2016) Decisions relating to cardiopulmonary resuscitation" guidance, is included in Appendix 4.

It is worth noting that:

- If the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and there is no realistic prospect of a successful outcome, **CPR should not be offered or attempted**
- **To withhold the specific treatment option of CPR, because it is considered to be futile, is a clinical decision.** Patients and their relevant others cannot insist that healthcare professionals provide a treatment that will not work
- Where the clinical decision is challenged or an objection is raised by a patient/relevant other, every effort should be made to reach a resolution through sensitive discussions. **If an agreement cannot be reached a second opinion should be offered**
- **If no resolution can be agreed a legal review may be necessary**

More detailed guidance surrounding DNACPR decisions can be found in The Resuscitation Council (UK) / RCN / BMA Guidance Decisions relating to cardiopulmonary resuscitation (2016)

5.3 Discussion with Patient/Relevant Others

The Resuscitation Council (UK) / RCN / BMA Guidance Decisions relating to cardiopulmonary resuscitation (2016) provide general guidance on deciding when and how approaches to patients and relatives should be made. The circumstances of each patient should be considered, and a plan formulated on a case-by-case basis. Discussions around emergency treatments should be undertaken sensitively. Healthcare Professionals should be responsive to verbal and non-verbal communication signals from the patient which may indicate the extent to which they wish to be involved in these discussions.

Each case involves an individual patient (and their relevant others) with their own particular circumstances and it is important to ensure that any recommendations regarding ReSPECT decisions are based on these.

The Court of Appeal's 2014 decision in R (Tracey) v Cambridge University Hospitals NHS Foundation Trust and others, makes it clear that the patient (and where requested by the patient, relevant others) should be involved in discussions about resuscitation.

Failure to consult with the patient may constitute a breach of their rights under Article 8 of the European Convention on Human Rights (ECHR). A ReSPECT decision should be completed and inserted in a patient's medical case notes after consultation with that patient. Only in exceptional circumstances where the treating clinician considers that "the patient will be distressed during consultation and the distress may cause harm" would it then be reasonable not to discuss a patient's resuscitation status/plan of care with them.

Harm can be psychological or physical. Distress alone would not be sufficient grounds to not discuss ReSPECT with the patient/relevant others. A clinical view that CPR or medical treatment is futile is not a sufficient reason to not inform the patient/relevant others.

Further guidance on the decision in Tracy can be found here:
https://www.39essex.com/cop_cases/r-tracey-v-cambridge-university-hospitals-nhs-foundation-trust-ors/

In the rare circumstances where a Healthcare Professional has sufficient grounds to believe

discussion with a patient or relevant others about their resuscitation status would cause that patient or relevant others harm, that Healthcare Professional must clearly record the reasons for this in the medical notes or Primary Care electronic record depending on the setting. Reasons for doing so must be robust and Health Professionals must be able to justify these.

Consensus amongst all those involved in the ReSPECT process and subsequent recommendation is the preferred aim. If consensus cannot be reached, a clear note of the reasons for the disagreement and the patient, relevant others or healthcare professionals expressing the disagreement should be made. Ultimately, the responsibility to complete the ReSPECT rests with the consultant /GP in charge of the patient's care.

Where the clinical recommendation is challenged or an objection is raised about the ReSPECT decisions by a patient or relevant others, every effort should be made to reach a resolution through sensitive discussions. **If an agreement cannot be reached, a second opinion and/or legal review may be necessary.**

Where there is a question about a patient's capacity to be involved in discussions about emergency treatments, an assessment of that patient's mental capacity must be carried out in accordance with the test set out in the Mental Capacity Act 2005. The starting point when undertaking any capacity assessment is a presumption of capacity**. The outcome of any mental capacity assessment performed must be recorded on the ReSPECT form.**

In patients who lack capacity there is a legal obligation to consult relevant others. Professionals must be mindful of the 2015 decision in Winspear v City Hospitals Sunderland NHS Foundation Trust. Specifically, this reminds professionals that:

- The MCA's s4(7) imposes a duty to consult those identified in s4 unless it is not practicable and appropriate to do so (i.e. actives steps must be taken to consult, rather than simply passively taking into account views that the decision-maker may be aware of)
- A failure to comply with that duty will mean that the decision-maker cannot then rely on the MCA's s5 defence in any claim brought for breaches of the ECHR.

This might mean delaying a DNACPR recommendation until reasonable and practical steps have been taken to consult the relevant others. Such steps may include telephoning at night, which whilst that might be less convenient or desirable than carrying out a meeting in office hours, may not need to be considered if no other option is practicable. In the case of a rapidly evolving clinical scenario, when urgent decision making needs to proceed before relevant others can be contacted, the following should be documented in the case notes:

- What attempts have been made to contact the relevant others
- The reasons why the DNACPR/treatment plan recommendation has been made without their consultation
- Clear instructions made that they relevant others are informed as soon as practically possible

For further guidance a framework can be found in Appendix 3: 'Making CPR decisions when the patient lacks capacity and further guidance on the decision in Winspear can be found here:
https://www.39essex.com/cop_cases/elaine-winspear-v-city-hospitals-sunderland-nhs-foundation-trust/

5.4 Reviewing a ReSPECT Document

A ReSPECT document should be reviewed:

- On transfer of care
- In response to any change in the patient's overall health status or their expressed wishes

The frequency of the reviews should be determined on a case by case basis, but generally a ReSPECT recommendation will remain effective unless cancelled.

When a ReSPECT document is cancelled, the form should be marked through with two parallel lines and the word 'cancelled' written clearly between the lines. The date, time, name and grade of person revoking the ReSPECT form should then be recorded on the form. The form should be immediately removed and filed in the correspondence section of the medical notes. Amended ReSPECT forms must not be destroyed as they are an important record of discussions and decisions. An entry fully recording the reasons for this change in recommendation must be made in the patient's medical notes or primary care electronic record, depending on the setting.

In a hospital setting medical staff must inform the nurse in charge of the patient's care whenever a change in a ReSPECT document is made. Within the Primary Care setting, the Healthcare Professional cancelling the form should ensure all those involved in the patient's care are made aware of the change and so that all appropriate records can be amended.

When a patient attends hospital with an active DNACPR form or ReSPECT document it should be reviewed with the patient. The nature of any review of ReSPECT will depend on the particular clinical circumstances of that patient. It may not be necessary to review the content of the document with the patient or relevant others if sufficient information has already been communicated. This will be a matter of clinical judgement for the Healthcare Professional with overall clinical responsibility for the patient, and other members of the healthcare team.

The outcome of the review should be recorded on a ReSPECT form, either by completing a new form, or by endorsing section 9 on the existing ReSPECT form.

If a ReSPECT form or DNACPR decision is revoked/cancelled or amended, it is the responsibility of the Healthcare Professional making the change to communicate this to all relevant parties involved in the care of the patient both in Primary and Secondary Care, so that any changes needed to existing records can be made.

5.5 Record Keeping and Internal/Interagency Communication

Good record keeping and effective communication are central to the safe and effective use of ReSPECT documents.

ReSPECT recommendations must be recorded on the nationally recognised form (which can either be a paper copy or amendable PDF format in some settings, such as Primary Care). All sections of the form should be completed and the circumstances surrounding the decision must

be clearly stated, together with who was involved in the decision-making process (see Appendix 2 for a quick guide to completing the form). The decision as well as the decision-making process, should be evidenced with full and clear documentation in the patient's medical notes or Primary Care electronic record, depending on what setting it is competed in.

Where an amendable PDF version is used, there must be the ability to print a colour copy that can remain with the patient and that either includes a digital signature or alternatively can be signed with black ink as proof that it is an original version.
Within a hospital setting, this should be filed at the front of the patient's medical notes and Nursing staff have a duty to record and maintain up to date nursing records of ReSPECT decisions including resuscitation status. Robust systems must be in place to ensure effective communication between shifts and whenever a patient is transferred between clinical areas (e.g. from ward to Radiology and back) or between Primary and Secondary Care. Communication of these decisions both internally and externally is essential. When a patient is moved between Secondary Care to Primary Care, it is essential that any decisions or updates are communicated clearly within the discharge letter.

Within the Primary Care records when a ReSPECT document is in place, and/or a decision has been made regarding CPR, this should be added to the patient's alerts or summary as separate entries to make the information easily accessible. In Secondary Care, if a DNACPR decision has been made as part of the ReSPECT process, this should be added to the patient's alerts on WEBV.

The ability to share scanned or electronic versions of the document will continue to change and evolve with the role out of the EPACCS systems (electronic palliative care co-ordination system). Where possible the ideal would be to upload the latest version of the ReSPECT document to the EPACCS record. Where an electronic version is used a digital signature is acceptable.

Despite this electronic sharing, due to the possible risk that an electronic record may not be updated, it will always be the printed paper copy that will be considered the valid most up to date version. If a decision is being made using an electronically held copy of a ReSPECT document, it is important that the Healthcare Professional making the decision check that it is the most up- to- date version. The NHS111 (YAS) staff will have access via to patient information via EPaCCS, the data is pulled from the Black Pear EPaCCS populating the Adastra SPN.

See Appendix 6 for agreed NLaG/Trust procedures.

The following principles apply**:**

ReSPECT recommendations can only be effective across healthcare settings if they are shared without delay with relevant healthcare professionals whose decisions it is intended to inform.

- The person who makes a ReSPECT decision is ultimately responsible for ensuring that the decision is communicated effectively to other relevant health professionals in both primary and secondary care. Effective embedding of the EPACCS system will support this. The task of disseminating information about the decision to others providing care to the patient may be delegated to another member of the healthcare team, but it should be clearwho has responsibility for ensuring that this task is undertaken
- The senior nurse is responsible for ensuring that every ReSPECT decision is recorded in

the nursing records (where medical and nursing records are held separately) and that all those nursing the patient are aware of the decision

- Whenever a patient is transferred between establishments or discharged home it is imperative that ReSPECT decisions are communicated between all who need to know, including the ambulance crew, GP, community nursing team, hospice, care home and any relevant others and this should be managed in a sensitive manner

5.6 What to do with DNACPR forms during the ReSPECT roll- out period

It is envisaged that the roll out of ReSPECT will take significant training and time period to embed. During this period, it will be possible to fill in either the regional DNACPR form or the ReSPECT document.

Once you as an individual or your area as a speciality (medicine/primary care/surgery) have completed training on the use of the ReSPECT document you should subsequently **only fill out ReSPECT documents, not the DNACPR form** and you will be encouraged if seeing a DNACPR form to transfer it after due discussion to a ReSPECT document.

During the phase in period if you have not had ReSPECT training you can continue to fill out the regional DNACPR form.

Once the roll out period has been completed, all blank regional DNACPR forms will be removed from clinical areas and **ONLY** blank ReSPECT documents will remain. From that point onwards, any new decisions will only be recorded on a ReSPECT document and all trained Healthcare Professionals who come across DNACPR forms should, following discussion with the patient, transfer the relevant decisions onto a ReSPECT document.

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.**

Similarly, a photocopy of a ReSPECT or DNACPR form (or an original black and white copy) 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 (or if the decision is documented on an historical DNACPR, this should be transferred to a ReSPECT form.

5.7 Training/Support

The ReSPECT implementation group have agreed the suggested competencies for individuals that will be filling out ReSPECT forms including DNACPR decisions as referred to in Appendix 5.

The group will also agree a list of recommended resources for training and will have a detailed roll out and implementation plan not covered in the scope of this policy that will include training, audit and communications across all organisations.

Support during the role out will be available from the ReSPECT document roll out facilitator and ReSPECT document implementation group.

6 REFERENCES

British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016) Decisions relating to cardiopulmonary resuscitation

British Medical Association (2007) *The mental capacity act 2005- guidance for professionals.*

Department of Health (2009) *Reference guide to consent for examination or treatment, second edition* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643 accessed 13.07.10

General Medical Council (2010). *Treatment and care towards the end of life: good practice in decision making*. http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

HM government (1989) *The Children ACT 1989* HMSO London

HM Government (2010*) Working Together To Safeguard Children 2010* DCSF London.

Human Rights Act (1998). London, HMSO.

Mental Capacity Act (2005) *Mental Capacity Act 2005*

Nursing and Midwifery Council (NMC) publication The Code- Professional standards of practice and behaviour for nurses and midwives (2015)

Tracey Court of Appeal Decision https://www.judiciary.gov.uk/wp-content/uploads/2014/06/tracey-approved.pdf

Aintree University Hospitals NHS Foundation Trust v James (2013)

Appendix 1: Sample ReSPECT document v3 page 1

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name

Date of birth

Address

NHS/CHI/Health and care number

1. This plan belongs to:

Preferred name

Date completed

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me — **Quality of life and comfort matters most to me**

What I most value:	What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
clinician signature		clinician signature		clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

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

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Appendix 1: sample ReSPECT document v3 page 2

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? ☐ Yes ☐ No Document the full capacity assessment in the clinical record.	If no, in what way does this person lack capacity? If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

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 this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) 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.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**

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

How to complete a ReSPECT form: Quick guide for clinicians

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

1. Personal details

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

Preferred name

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

2. Summary of relevant information for this plan

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

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

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

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

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

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

4. Clinical recommendations for emergency care and treatment

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

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

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

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

5. Capacity and representation at time of completion

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

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

6. Involvement in making this plan

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

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

7. Clinicians' signatures

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

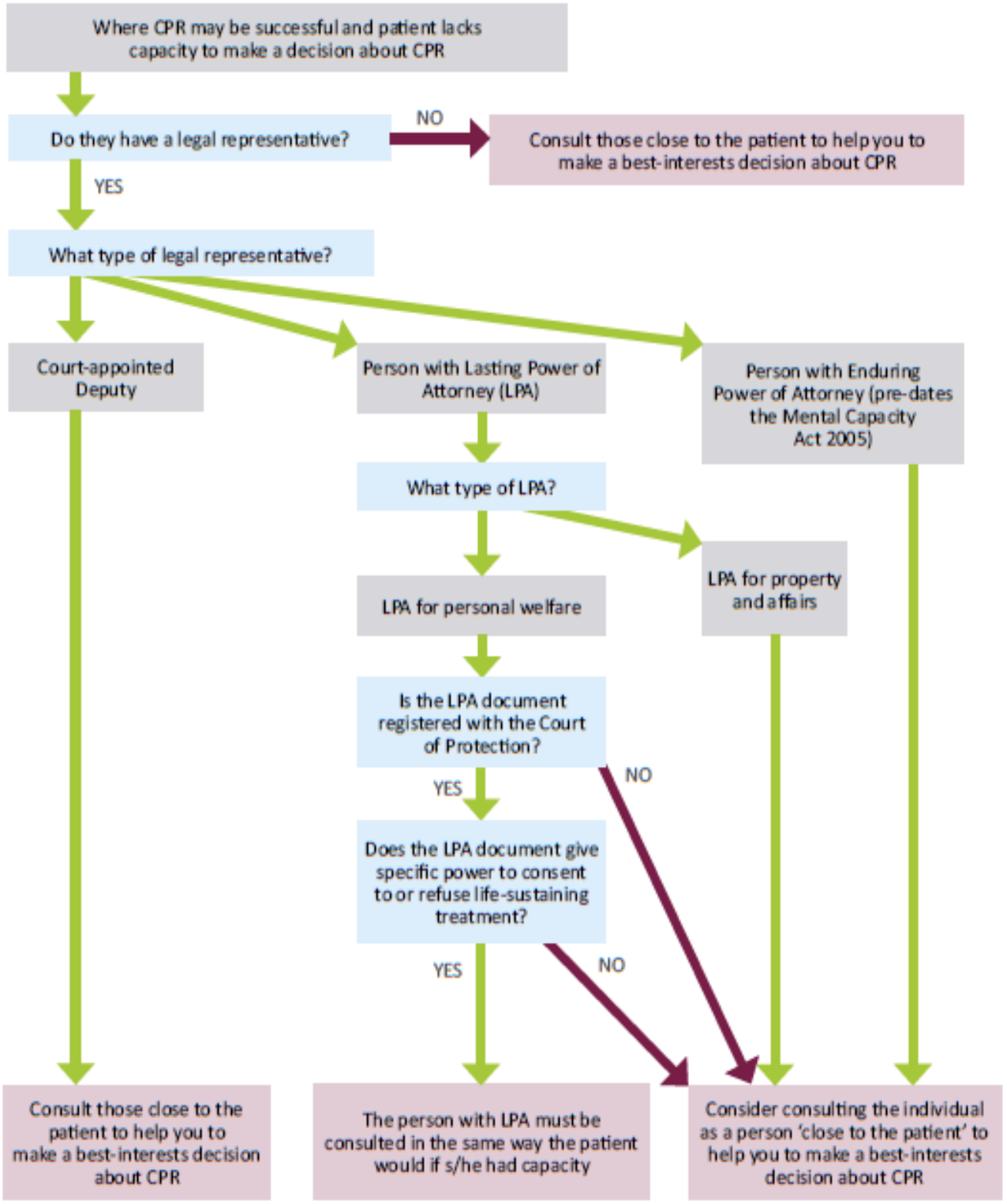
8. Emergency contacts

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

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

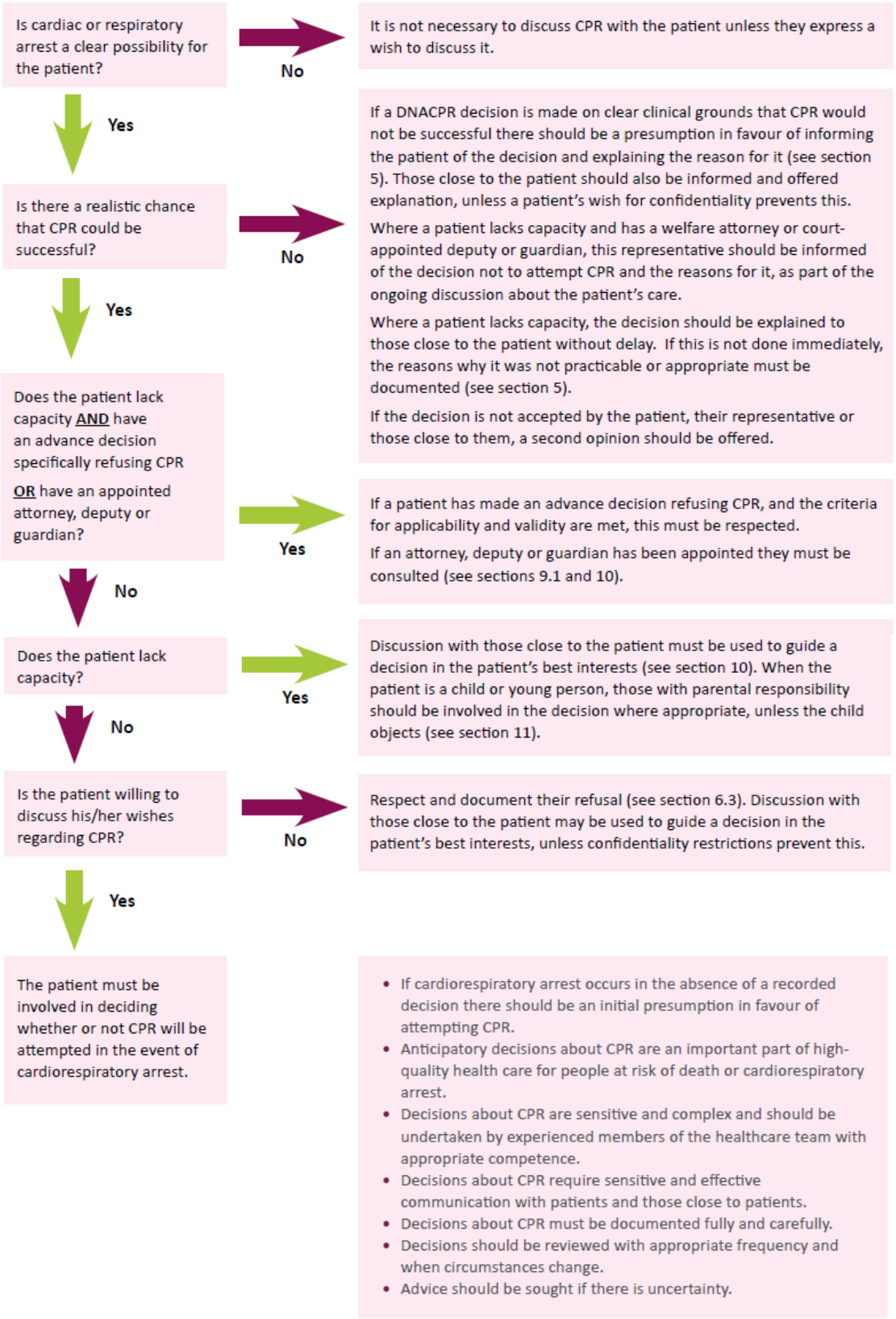
This section should be left blank at the time of initial completion of the plan. Remember to document in the health records whether and when review of the recommendations on this ReSPECT form should be considered. The recommendations on the ReSPECT form do not have a defined expiry date, as the need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

Appendix 3: Making CPR decisions when the patient lacks capacity



In all situations, where CPR will not work it should not be offered. This decision and the reasons for it should be explained carefully to those representing and those close to the patient. Where there is objection to or disagreement with this decision, a second opinion should be offered. The court may be asked to make a declaration if it is not possible to resolve the disagreement.

Appendix 4: CPR decision making Framework



Appendix 5: Training competencies for senior doctors and nurses having ReSPECT conversations including DNACPR decisions

(For ST3 and above in Acute Setting and GP within community training may only need to cover sections highlighted yellow as presumption made they have already had training in DNACPR decision making. All other doctors and healthcare staff would need to cover all the competencies)

Competencies for training doctors and nurses how to make DNACPR orders

A simpler version of the key points can be offered to 'non-decision makers' such as ward RNs, foundation doctors and AHPs on mandatory resuscitation courses.

- Important to stress to ward RNs and junior doctors that while CPR is the default response if there is no documented CPR decision, they will be supported if they decide not to start CPR in a patient with advanced signs of irreversible death such as rigor mortis or a person in the terminal stages of a chronic disease where death is imminent and it has been impossible to find a senior doctor to make a DNACPR decision.
- They will also be supported if they decide to start resuscitation for a patient with a DNACPR order or applicable and valid ARDT who has developed life threatening problems not anticipated by the DNACPR/ADRT. For example, choking a blocked tracheostomy or displaced/blocked ET tube, to mention a few.

Competency	Explanation to candidates
Competency 1. Recognise when and for who to initiate ReSPECT/CPR discussions	CPR: 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 ReSPECT: should not be limited just to those who are approaching end of life and remains an important consideration for (but not limited only to) those with significant frailty or chronic progressive long term conditions for whom prognosis could realistically be expected to be less than a year. Anyone who wishes to make some advance wishes
Competency 2. Recognise when CPR *will not* be successful and when CPR *may be* successful	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. Be aware of what circumstances would lead a clinician to believe CPR is clinically futile.
Competency 3. Be aware of decision-making framework for CPR discussions in patients with or without capacity	See framework in appendix 3 and 4
Competency 4. Understand what action to take if a patient with capacity is unwilling to discuss a CPR decision.	Respect this decision. The patient may be willing for the clinician to discuss with relevant others but respect the patient's decision if they refuse this option.
Competency 5: Be aware what action to take if a patient or relative disagrees with a DNACPR or ReSPECT form recommendations	If the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. To withhold the single treatment option of CPR because it will not work, is a clinical decision. Patients and their relevant others cannot insist that Healthcare Professionals provide a treatment that will not work. Offer second opinion
Competency 6: Be aware of the responsibility to discuss DNACPR/ReSPECT documentation with patients/ relatives	Any decisions about treatment and/or CPR should always be communicated to the patient, if they have sufficient mental capacity, or relevant others (subject to any confidentiality restrictions) except in the exceptional circumstance that consultation is likely to cause physical or psychological harm to that patient/relevant others.

Competency 7: Be aware of the practical aspects of completing a ReSPECT document	See quick guide in appendix 2 The decision must then be discussed and agreed with the senior clinician responsible for the patients care and their agreement confirmed and documented. Within NLAG requirement for the responsible consultant to review and endorse the form within 48 hours. There is not a similar requirement for GP's given 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.
Competency 8: Be aware of the range of scope involved in a ReSPECT discussion and aware of own ability to have the conversation in individual scenarios	ReSPECT focuses on treatments to be considered as well as those that are not wanted or would not work. Such life-sustaining treatment could include, but is not limited to admission to hospital, antibiotics, fluid resuscitation, clinically assisted hydration or nutrition, admission to ICU for intubation and ventilator support, inotropic and other cardiovascular support, as well as CPR. It is possible that an individual will feel competent to complete a ReSPECT form (including CPR decision) for some individuals and not others depending on their own experience and competence ie. a specialist respiratory nurse may feel competent to have a discussion with a patient whose underlying condition is COPD/pulmonary fibrosis but not for a patient with progressive cancer due to their underlying understanding of the disease processes.
Competency 9. Other key points the candidate must understand	• No CPR decision – presumption to start CPR if arrest occurs • You can have a ReSPECT document and still be for resuscitation. It is crucial that a ReSPECT document is not confused with being a DNACPR decision. • CPR/ReSPECT decisions require sensitive and effective communication. *Role play* is an excellent way of developing these skills in suitably experienced nurses and doctors. Stress importance of explaining that to patients/relevant others that other beneficial treatments will not be withheld. A DNACPR does not mean 'giving up' on the patient. • ReSPECT is not a legally binding document. It does not override clinical judgment in the event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged when the recommendation was made, provided that there is not a valid and applicable advance decision expressly refusing such intervention. Examples for overriding ReSPECT/DNACPR in favour of treatment include choking, blocked tracheostomy. • If a ReSPECT form or DNACPR decision is initiated/revoked/cancelled or amended it is the responsibility of the health care professional making the change to communicate this to all relevant parties involved in the care of the patient both in primary and secondary care so that any changes needed to existing records can be made. • It is envisaged that the roll out of ReSPECT will take significant training and period to embed. During this period, it will be possible to fill in either the regional DNACPR form or the ReSPECT form. • If a decision is being made using an electronically held copy of a ReSPECT form it is important that the individuals making the decision check that it is the most up to date version. • It will always be the printed paper copy that is the valid most up to date version • It is possible that a patient may have a DNACPR decision or other emergency care and treatment plan documented on a different 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. • Similarly, a photocopy of a ReSPECT or DNACPR form (or an original black and white copy) 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 (or if it is a DNACPR form to transfer to a ReSPECT form. • A digital signature is valid on an electronic version of the ReSPECT form

Appendix 6: STORAGE OF THE ReSPECT FORM (NLaG) AND INTERNAL/INTERAGENCY COMMUNICATION

Introduction

The flow of information and correct documentation is crucial to the success of this process. Where an individual may move care settings, including on discharge to the patient's home, and the **ReSPECT** decision has been reviewed **and still applies**, the following core principles apply:

Whilst in Hospital

- Whilst in Hospital, any current ReSPECT form must be filed at the front of the notes
- If the ReSPECT is valid on discharge, the original copy should be sent with the patient and the 'copy' filed at the front of the case notes

Management of ReSPECT forms initiated outside the Trust

- When a patient is admitted to hospital with an existing valid form, this should be copied, and the word 'copy' should be written on it. The copy should be filed with the original in the case notes. If the patient is discharged the original should be returned to the patient prior to leaving the hospital. If the decision is cancelled or updated the same process should be applied as for all ReSPECT forms

On Discharge/ Transfer

- On discharge, the top copy of the form will follow the patient to their destination (this could be patients own home, nursing home or other care facility). When the top copy (original copy with ink signature) of the form is following the patient to another setting, the second copy of the form (watermarked COPY) is to remain in the medical records. As the patient moves between care settings (including the patient's home), the ReSPECT form moves with the patient in a clearly marked envelope and remains in their possession
- When a patient travels by ambulance, the discharging ward/department will give the original ReSPECT form to the ambulance crew in a clearly marked envelope who will formally handover the ReSPECT form to the member of staff receiving the patient, or to the patient/relevant others on arrival at their destination
- When a patient travels by other means ie. with relevant others, it is essential that the ReSPECT form is given to the patient or relevant others (as appropriate) and that they understand its importance. **This is the final part of the ReSPECT process and should not be the first time the patient and if appropriate relevant others are made aware of its existence**
- In all other care settings (which may include the patient's home) the ReSPECT form should be located in the front of the care/nursing record. If no nursing record exists, the patient/family/carer will determine the best place to store it and communicate this to appropriate health care professionals ie. warden/carer/district nurse for future access if required

- It is essential that as part of discharge planning, the doctor responsible for the patient's care informs the patient's GP. **Information about ReSPECT must be included in the discharge letter in the future management GP section on the JAC system** and out of hours service as appropriate. This role may be delegated but is paramount to the communication process
- All other care providers must also be informed about the ReSPECT PRIOR to discharge i.e. carers/wardens/district nurse etc., this role may be undertaken by the ward nursing staff as part of discharge planning

Liaison with Ambulance Services

- Ambulance control must be informed that a ReSPECT form exists at the time of booking a patient transport services (PTS) ambulance
- Ambulance crew (the registration clerk) will routinely request the DNACPR status at the point of booking patient transport services and communicate this to the crew
- If an ambulance is called in an emergency that is not life threatening but requires transfer to ED, ie. from a community hospital or home, the crew will be handed the care record with the ReSPECT form at the front of it, **or** a clearly marked envelope with the ReSPECT form in. On arrival at ED the crew will formally handover the ReSPECT form to the member of staff responsible for the patient

Cancelling a ReSPECT Form

To cancel a ReSPECT form, both copies must be marked with two diagonal lines and the word CANCELLED should be written across the form between the lines with the date and the signature of the clinician cancelling the form. The rationale for cancelling the form should be documented within the medical records and should state who this has been discussed with. Both copies (where available) should be filed within the main body of the medical records.