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Norfolk and Waveney Integrated Care System

Norfolk & Waveney Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy

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Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet or document management system.

Consultation

The following were consulted during the development and/or review of this document:

- Acute Hospital Collaborative
- Age UK Norwich
- Carers Voice Norfolk and Waveney
- East Anglia's Children Hospice (EACH)
- East of England Ambulance Service
- Healthwatch Norfolk
- Integrated Care 24
- James Paget University Hospital
- Marie Curie
- Later Lives Network
- Norfolk & Suffolk Care Support Ltd
- Norfolk & Waveney Integrated Care Board
- Norfolk & Waveney Local Medical Committee
- Norfolk and Norwich University Hospitals
- Norfolk and Suffolk Foundation Trust
- Norfolk Community Health & Care/Priscilla Bacon Lodge
- Norfolk County Council
- Social Care and Health Partnerships
- South Norfolk Healthcare Community Interest Company (CIC)
- St Elizabeth Hospice
- Tapping House Hospice
- The Queen Elizabeth Hospital

Change Control

No individual organisation is permitted to makes changes to this document.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document.

Relationship of this document to other procedural documents

This document is a policy applicable to Integrated Care System.

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Quick reference guide ReSPECT

Step 1- Identify the need for a ReSPECT conversation

Step 2 – Plan the conversation

Provide ReSPECT information to the person and/or their personal preferred advocate prior to a conversation

Identify an appropriately trained/qualified person to initiate and lead on the Respect conversation

Identify who the person would/would not wish to be present

Consider when and where the conversation will take place

Step 3 – ReSPECT conversation(s) and documentation completed

Step 4 Senior Responsible Clinician (SRC) signs off the ReSPECT form

Step 5 Post Sign Off

ReSPECT form to remain with the person or the personal preferred advocate

ReSPECT form is to be Reviewed:

- When the person changes care setting
- If the person's condition changes
- If the person's wishes or preferences change

1 Introduction

1.1 Rationale

ReSPECT stands for **Recommended Summary Plan for Emergency Care and Treatment.** The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

1.2 Objective

The objective of the ReSPECT process is to create conversations between a person and one or more care professionals who are involved with their care. The current ReSPECT document should stay with the person and be available to care professionals when faced with making immediate decisions in an emergency.

1.3 Scope

The ReSPECT plan can be for any individual but will have increasing relevance for people who have complex health needs, people who are nearing the end of their lives or people who are at risk of sudden deterioration or cardiac arrest.

1.4 Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
ACP	Advance Care Plan
CPR	Cardiopulmonary resuscitation
GP	General Practitioner
Healthcare Professional	Is a person registered with any of the following professional bodies, who is permitted by that body to provide or supervise the provision of the regulated activity: Health and Care Professions Council. Nursing and Midwifery Council. General Medical Council. General Dental Council
Healthcare Records	Electronic and/or paper health documentation forming an individual's record
ICB	Integrated Care Board
IMCA	Independent Mental Capacity Advocate - statutory advocacy to represent those who lack capacity and are unable to choose and advocate to represent them
LPA	Lasting Power of Attorney (health and welfare) - are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.
MCA	Mental Capacity Act
NHS	National Health Service

Patient Identifier	Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended
Person	An individual who may also be known as a patient, includes children or young person
Preferred Personal Advocate	Somebody who represents the persons wishes and preferences when the person is unable to do so
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SRC	Senior Responsible Clinician
ST3	Specialty Trainee (year) 3

2 Respect Conversations and Documentation

2.1 ReSPECT Conversations.

2.1.1 Identifying the need for a ReSPECT conversation.

A person, or anyone involved in their care, may identify that a ReSPECT conversation would be appropriate. This may be based on the person expressing a desire to communicate their wishes and preferences or based on the current/prognosed state of their physical and/or mental health, or for a person who is generally quite well who wishes to have a plan in place in the unfortunate circumstance of an accident or sudden medical crisis in which their physical and/or mental capacity could be affected.

When the need for a ReSPECT conversation has been identified, it should be communicated to a healthcare professional for further action. For example, in:

- A care/residential home setting, to their aligned GP practice.
- A domiciliary setting, to the person's GP or if receiving NHS community healthcare, to a Community Nurse.
- A community physical or mental health inpatient setting, to the Doctor, Advanced Clinical Practitioner or Senior Nurse.
- An acute hospital setting, to the Consultant Team responsible for their care until discharge.

2.2 Who can Lead on a ReSPECT conversation?

The Lead for a ReSPECT conversation with the person or their preferred personal advocate must be a doctor or a clinician with experience in advance care planning (ACP) e.g. Registered Nurse or Paramedic, or Physician Associate (if within their agreed supervised scope of practice). However, anyone involved in the care of a patient may initiate a conversation about advance care planning or ReSPECT, if they are competent to do so. To ensure ReSPECT conversations are undertaken to a high standard, and to ensure compliance with important medico-legal aspects of law, it is highly recommended that clinicians undertake ReSPECT Level 3 Training (see section 3 – ReSPECT Training).

2.3 Planning a ReSPECT conversation.

In majority of circumstances there will be adequate time for the clinician who will be leading a ReSPECT conversation to prepare in advance. Preparation may include:

- Sharing useful information on ReSPECT with the patient/personal preferred advocate prior to a conversation where possible.
- Gaining a good understanding of the person's current physical and/or mental health and any associated prognosis.

The NHS have a statutory responsibility to follow the Accessible Information Standard 2016, which means a person's communication and information needs must be identified and supported. This means language should be adapted to the level and means the person requires whenever possible. Steps must be taken to ensure that simplifying information does not change the important details. Ensure the second principle of the Mental Capacity Act (MCA) is applied by ensure the person has been given all practicable help to make their own decision before they are assessed to lack capacity including involvement of a family member or advocate.

2.4 Factors to considering when planning a ReSPECT conversation.

Who would the person wish to be present and who they would not want to be present?

Offer and record the opportunity for preferred personal advocate support.

When (Time) in illness. Early / later – this should be chosen in accordance with person preferences and circumstances and should not be left until it is too late for the person to be directly involved.

When (Time) in the day. Consider any known fluctuations in the person's cognitive state based on time of day.

Where should the conversation occur? In an environment familiar to the person. Try to avoid conversations when the person is acutely unwell for example in the Emergency Department or hospital assessment unit.

However, there may be unexpected emergency situations when a ReSPECT conversation needs to take place urgently, either with the patient or (in the event that the patient lacks capacity) with the preferred personal advocate. In a situation where the patient lacks capacity to make a decision to be involved and express wishes and preferences towards ReSPECT conversations and attempts to contact the preferred personal advocate are unsuccessful, an emergency decision on CPR (and other aspects of care) can be made and documented on the ReSPECT form, but ongoing attempts must still be made to contact the preferred personal advocate and this must be documented.

2.5 The ReSPECT conversation – Main principles.

The following points represent a 'best practice' approach to holding ReSPECT conversations and it is strongly recommended that they are adhered to:

- The 'duty to consult' is recognised as a fundamental aspect of healthcare and should be viewed as applying to both CPR and other potentially life-saving treatments.[1]
- Full compliance with the requirements of the Mental Capacity Act 2005 including the following principles:
    - Every person (16 years and over) has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
    - A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
    - People have the right not to be treated as lacking capacity merely because they make a decision that others deem 'unwise'.
    - Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.
    - Someone making a decision or acting on behalf of another person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all.

2.5.1 The conversation should include:

- Confirming that a person understands that a healthcare professional is involving them in a discussion about their current and future care planning.
- The health professional is not asking for their consent or informing them of a decision already made.
- The ReSPECT process does not provide 'advance consent' - there being no requirement in law for this.[2] However, this would be essential to any subsequent best interest decision making.[3]
- Discussion about the person's current state of health, reaching a shared understanding of this and how it may change in the foreseeable future.
- Identifying the person's preferences and goals for care in the event of a future emergency.
- If beneficial for the person, to summarise discussions with an agreed focus of care as being more towards life-sustaining treatments or prioritising comfort rather than efforts to sustain life.
- Ensuring an understanding that a ReSPECT form is not a legally binding document but a recommendation for future treatment and care, which can change at any time.
- Understanding the person's right to confidentiality, in particular with who the ReSPECT form will or will not be shared with but understanding that it will be shared with healthcare professionals involved in the person's direct care, in accordance with the Caldicott Principles (of Confidentiality) and the Mental Capacity Act 2005.

Making and recording in the person's healthcare records and on a ReSPECT form, a shared understanding about specific types of care and realistic treatment that a person would want considered, or that they would not want, and explaining sensitively about treatments that would not be clinically appropriate. If there is any uncertainty on the part of the lead about which care options would be realistic or appropriate this should be discussed in advance with a senior doctor. (e.g. CPR, escalation to critical care or admission to hospital).

Any significant disagreements and differences in expectations between a person/preferred personal advocate and the healthcare professions should be dealt with positively and proactively, if possible, deferring any recommendations and strongly considering the offer of a second opinion.

Where the person has the mental capacity to take part in the making of the ReSPECT recommendations, there is a requirement that they be involved with the process. The Tracey judgment outlines the legal requirement to involve patients in discussions regarding CPR recommendations unless doing so would cause significant physical or psychological harm - distress is not enough.[4] If a person has not been involved or does not wish to be included in discussions about potential life-sustaining treatments, including CPR, this should not be forced upon them, and a person's agreement should be sought to involve those close to them.[5]

Where there is concern about a person's capacity to make a decision regarding being involved within the conversation and express wishes and preferences towards ReSPECT recommendations, an assessment under the Mental Capacity Act should be completed and recorded on the appropriate form.

If the person is considered to lack capacity to be involved in their future care planning, professionals should first apply any valid and applicable Advance Decision to Refuse Treatment.

The *Winspear* judgment ratifies the *Tracey* judgment and expands to someone lacking the capacity to participate in the making of the recommendations, requiring instead consultation (where practicable and appropriate) with those interested in their welfare, especially a Lasting Power of Attorney for Health and Welfare, Court Appointed Deputy; or close family member [6]

If the person lacks capacity to be involved with decisions to be made, and they have no personal advocate, a referral for an Independent Mental Capacity Advocate (IMCA) should be made to ensure they have representation, as soon as time and circumstances allow.

The ReSPECT document can be used as a guide to best interest decision-making by an HCP in an emergency including potentially life sustaining treatment.

2.6 Documenting a ReSPECT conversation.

Following a ReSPECT conversation, documentation must be completed contemporaneously (at the same time) in the person's healthcare record (electronic

or paper) where access to the clinical system is available at the time. The following points MUST be documented:

- When and where the ReSPECT conversation took place and who was present.
- Where an assessment of a person's capacity to make a decision is required, there should be a completion of the appropriate form including detail of the person's wishes, feelings and beliefs.
- If a preferred personal advocate for the person was involved, who they are by name and relationship.
- A summary of the discussions.
- A shared understanding about whether or not CPR is recommended. If CPR is not recommended, a clinical rationale should be included.

2.7 Completing a ReSPECT form

ReSPECT documents can be completed in hand-written format or electronically. If hand-written, black ink should be used.

Ideally the ReSPECT document should be completed by the clinician leading on the ReSPECT conversation. However, in some cases, the person or their preferred personal advocate may be given a blank ReSPECT document prior to conversations to allow them to read through it, consider its content and allow time for them to form questions that they may wish to ask during the conversation.

In some cases, the person or their preferred personal advocate may also wish to complete the document in advance of a conversation. This is perfectly acceptable, however the clinician undertaking the conversation may have to transfer the information to a new document following the conversation to ensure compliance to the points below.

- It is very important that a completed ReSPECT document is legible and uses language that can be easily understood by anyone that will need to read and consider its recommendations in an emergency situation.
- The person's details (including three person identifiers) must be completed in Section 1 'This plan belongs to'. A patient identification label can be used and stuck onto this section, provided the label contains the same demographic information as the ReSPECT document. Do not use a 'Hospital Number' instead of an NHS number.
- If new additions are made to 'Clinician's signatures' (Section 7) or 'Emergency Contacts' (Section 8), there is no need to complete a new document. These can be added to the original document.
- Where errors are made, or if the document is reviewed and changed, information must not be crossed or scribbled out or correction fluid used. A new document is to be completed.
- Ensure all sections of the document are completed (no blank spaces) paying particular attention to section 4 of the ReSPECT form (clinical

recommendations for emergency care and treatment). In cases when a person may not have a specific preference to something on the document e.g. 'What I most value' or 'What I fear/wish to avoid'. the clinician should complete the document with (for example) "No preference given by the person at this time". This indicates the questions were included in the conversation.

- The person or their preferred personal advocate should have their details completed in Section 8 of the ReSPECT document Emergency contacts and those involved in making the plan, although optional, should be encouraged to add their signature. This confirms their involvement in the ReSPECT process.
- Provide the patient with a hard copy and place a copy within the health records

2.8 Senior responsible clinician (SRC) signoff

A senior responsible clinician (SRC) is the person with overall responsibility for a person's care. This may change if the person moves across care settings e.g. at home, a person's SRC would be their GP however if the person should move to a hospital setting, it would become a Consultant, hospital doctor (of ST3 grade or above).

An SRC has delegated authority from the employing organisation in accordance with policy.

For the purpose of ReSPECT the following groups are eligible to act as approved multi-professional senior responsible clinicians:

1. Consultants and GPs
2. Resident doctors ST3 and above (or equivalent grade)
3. Senior nurse specialists
4. Senior nurses in leaderships roles
5. Advanced clinical practitioners

The list above is not exhaustive, other senior clinical staff could be considered depending on the criteria below.

Eligibility to be a non-medical multi-professional SRC is dependent on:

1. Delegated authority from the employing organisation in accordance with policy.
2. Appropriate training to ReSPECT Level 3 Training (see section 3 – ReSPECT Training).
3. Supervision and mentoring when required in complex cases from the approved medical SRC

The Norfolk & Waveney ICB do not recommend social care nursing staff act as SRC.

A completed ReSPECT document should be signed off by a Senior Responsible Clinician at the earliest opportunity Section 7 (clinician's signatures).

If the SRC is also the person who completed the document, they do not have to duplicate their details in the other areas of Section 7. This means that a completed ReSPECT document is perfectly valid with only one clinician signature.

2.9 Reviewing a ReSPECT document (ReSPECT form) – Main principles

The ReSPECT document MUST be reviewed and when necessary updated:

- When the person changes care setting on discharge from a hospital e.g. back to a care home or to a residential address. The review must ensure the language is appropriate to be understood in the new care setting.
- If the person's condition changes to such a level (e.g. clinical improvement or deterioration) as to warrant a change to the recommendations the SRC should consider the persons capacity to make the decision at hand and complete an MCA assessment if appropriate.
- If the person's wishes or preferences for care change.

ReSPECT forms that have been reviewed and replaced should be clearly crossed through and marked as cancelled.

2.10 Sharing information about a newly completed ReSPECT document and keeping the original document safe.

When a ReSPECT document is completed it is very important the original document is kept safe and made easily available in an emergency situation.

The original document must be retained by the person and a copy taken for the healthcare records and the original MUST be given back to the person on discharge from a hospital or outpatient setting.

Hospital discharge letters e.g. to the person's GP, MUST include information relating to the newly completed ReSPECT document. An electronic copy of the document should be attached to the electronic discharge letter.

Where possible, a completed ReSPECT document should be included within the Shared Care Record. An electronic (scanned) copy may also be uploaded/saved to a person's electronic healthcare record.

The person MUST be made aware of the significance of the document and informed how important it is to keep it safe and accessible in the place where they live in a:

- 'Thinking Ahead' yellow folder
- 'Lions International Message In A Bottle'[7]
- prominent position at the bedside or in the fridge

2.11 Invalidation of ReSPECT:

Only a valid and applicable Advance Decision to Refuse Treatment is legally binding. However, a ReSPECT form represents a non-legally binding clinical recommendation for future provision of care, which informs and supports a

healthcare professional to make a decision at the required time. There is very little that will invalidate it:

- if a form is clearly for the wrong person
- it appears to be maliciously or fraudulently altered (please refer to the organisations safeguarding policy)
- the form has been crossed through and marked as cancelled

A ReSPECT decision is valid so long as an originator signature is present in the Clinician Signature section (Signed by a registrant (e.g. doctor or by an authorised nurse or AHP with Level 3 training.) The decision should be reviewed and signed by an SRC at the earliest opportunity.

Failure to involve a person or the preferred personal advocate in a recommendation not for CPR does not strictly invalidate a form but would show a failure of legal duty in process. A ReSPECT document must be evaluated and assessed for its applicability to the current clinical situation: It should neither be dismissed without consideration (e.g. an absent Senior Responsible Clinician Signature, or the lack of an original (colour) document), nor followed at all times automatically. It is important the assumption for CPR always remains unless, with all the available evidence, this is inappropriate.

Any responder (e.g. professional carer, ambulance staff) who makes a decision to invalidate a respect form and therefore not act on its recommendations or persons preferences MUST escalate this situation as soon as possible to the current senior clinician responsible for the person's care.

2.12 Children and Young People

For those wishing to use ReSPECT for children and young people visit the Child and Young Person's Advance Car Plan Collaborative website Standard Advance Care Plan (with and without ReSPECT) – CYPACP

3 Training & Competencies

3.1 Training Overview.

The ReSPECT process can only be successful across Norfolk and Waveney ICS with a uniform and standardised approach to education and training. All organisations within the ICS who have signed up to the ReSPECT Charter and Policy are expected to embrace the requirements of ReSPECT training for appropriate staff groups.

ReSPECT training is available at three levels with each level having identified Core Learning Outcomes and each level aimed at differing staff groups (see below). These learning outcomes reflect the minimum level of education/training in relation to ReSPECT at each of the three levels.

Where appropriate, organisations delivering in-house ReSPECT training to their own staff may include additional learning outcomes tailored to their organisational needs.

3.2 Differing Levels of ReSPECT Training & Education.

3.2.1 Level 1 - ReSPECT Awareness.

ReSPECT Awareness should be undertaken by any person who learns Cardiopulmonary Resuscitation (CPR) as a part of their role but are not directly involved in aspects of clinical or social care, e.g., hospital porters, administration staff in some cases and/or domestic services. Individual organisations may want to consider ReSPECT awareness training for volunteers or others who do not have CPR training but have direct contact with patients.

Recommendations for Training implementation:

- Session timing: 5-10 minutes.
- Delivery method: As an addition to Basic Life Support (BLS) Theoretical/practical training.

3.2.2 Level 2 – ReSPECT Reader.

ReSPECT Reader is aimed at health and social care staff who have a responsibility and duty of care for a patient/resident with a completed ReSPECT document. Organisations should also consider ReSPECT Reader training for staff who may not necessarily be required to complete Cardiopulmonary Resuscitation (CPR) training but their role entails advance care planning conversations**.**

Recommendations for Training implementation:

- Session timing: 20 – 30 minutes.
- Delivery method: Face to face training session or E-learn presentation.

3.2.3 Level 3 – ReSPECT Conversations and documentation.

ReSPECT Conversations and Documentation is aimed at registered health and social care professionals who may be called upon to undertake the ReSPECT process with a patient/resident e.g., hold conversations and complete all appropriate documentation including the ReSPECT document.

Recommendations for Training implementation:

- Pre-course reading and revision
- Session timing: 60-90 minutes.
- Delivery method: On-line presentation.

On-course training session:

- Session timing: 6 contact hours.
- Delivery method: Face-to-face.

Experienced doctors may not require this training as they may have the required knowledge already. The employing organisation should assess the training needs of its staff.

3.3 ReSPECT trainers and facilitators.

Any person delivering ReSPECT training at any level must have appropriate knowledge and experience of the ReSPECT process to ensure accurate and up-to-date information is delivered within the set core Learning Outcomes.

Any person designing/authoring ReSPECT learning materials for use at levels 1 to 3 such as e-Learns, precis/handouts, must ensure that such materials reflect accurate and up-to-date information. Where necessary, such learning materials should carry a version control number and be dated. In addition, such learning materials should be reviewed regularly by the author or their designated deputy and updated where necessary.

4 References

1. *Tracey v Cambridge University Hospitals NHS Foundation Trust* [2014] EWCA Civ 822 s55. bailii.org/ew/cases/EWCA/Civ/2014/822.html
2. Ruck Keene, A et al *Mental Capacity Report – July 23.* 39 Essex Chambers pg 10-11 HYPERLINK "https://www.39essex.com/information-hub/insight/mental-capacity-report-july-2023"https://www.39essex.com/information-hub/insight/mental-capacity-report-july-2023
3. Mental Capacity Act 2015 s4(6); *Aintree University Trust v James* [2013] UKSC 67 s39. https://www.supremecourt.uk/cases/docs/uksc-2013-0134-judgment.pdf
4. *Tracey v Cambridge University Hospitals NHS Foundation Trust* [2014] EWCA Civ 822 s53-54. bailii.org/ew/cases/EWCA/Civ/2014/822.htm
5. British Medical Association et al, 2016 pg11; General Medical Council s135,142
6. *Winspear v City Hospitals Sunderland NHS Foundation* Trust [2015] EWHC 3250 bailii.org/ew/cases/EWHC/QB/2015/3250.html
7. Lions Clubs lionsclubs.co/Public/message-in-a-bottle/

5 Monitoring Compliance of the policy to be delivered

Compliance with the process will be monitored through the following:

It is the responsibility of the individual organisation to take ownership of monitoring compliance with this policy, with the outcomes reportable through their own governance processes.