

# ReSPECT

## Recommended Summary Plan for Emergency Care and Treatment

### Place policy for use across all organisations in Sheffield

Sheffield Teaching Hospitals   
NHS Foundation Trust

  
South Yorkshire  
Integrated Care Board



Primary Care  
Sheffield 

  
Sheffield Health  
and Social Care  
NHS Foundation Trust

Sheffield Children's   
NHS Foundation Trust

Bluebell  
Wood  
CHILDREN'S HOSPICE 

St Luke's  
Sheffield's Hospice

**This citywide policy describes the best practice approach to the implementation of ReSPECT.**

**This can be adopted by organisations locally or it can be referenced to and used to inform local standard operating procedures for the implementation of ReSPECT.**

## Sheffield – ReSPECT Policy Summary

### Summary points

- The ReSPECT plan acts as a summary of key information for future emergency care and treatment at a time when a patient may not be able to express what matters to them. This policy template refers to recommendations about a range of emergency care and treatment options. Life-sustaining treatment could include admission to hospital, antibiotics, fluid resuscitation, admission to Critical Care for intubation and ventilator support, inotropic and other cardiovascular support, as well as cardio-pulmonary resuscitation (CPR).
- Advance decision making about emergency care and medical treatment is a collaboration between a person, their family and their healthcare professionals. In an emergency situation, it is vital that healthcare professionals have a clear understanding of what is important to a person and record realistic care and treatment recommendations including those about CPR.
- All care and treatment recommendations must be clearly recorded on the ReSPECT plan. This could include preferences about Critical Care admission, drug or other treatments. **A patient can have a ReSPECT plan and be for CPR.**
- **ReSPECT plans are not legally binding.** The ReSPECT plan should be regarded as a summary of an advance clinical assessment with recommendations, recorded to guide immediate clinical decision-making in the event of deterioration in a person's physical health or cardiorespiratory arrest. It constitutes an 'advance statement' under the terms of the Mental Capacity Act 2005, rather than an 'Advance Decision to Refuse Treatment (ADRT)'. The decision regarding whether or not to attempt CPR or other life-sustaining treatment should be made by the healthcare professionals responsible for the person's immediate care at the time of the emergency.
- A ReSPECT plan complements additional detailed advance care planning documentation, such as ADRT, Ok to Stay documents – it does not replace them. Details of these conversations must be recorded in the healthcare record.
- **Healthcare providers, who are uncertain about the need to give life-saving care, should always presume to save life.** Emergency care should be given until any previously agreed recommendations are clearly understood – this clarity is the purpose of the ReSPECT plan.
- ReSPECT plans must be reviewed when a person's clinical condition or what matters to them during an emergency significantly changes. A review may be considered when they are transferred / admitted / discharged from one healthcare provider to another.
- ReSPECT plans **MUST** stay with the individual so that health and care providers can easily access them. They should, where possible, also be recorded on the patient's digital record.
- DNACPR forms will still be recognised in Sheffield as ReSPECT is implemented across the health and social care system. It is recommended that patients who have current DNACPR forms should have a ReSPECT conversation and a plan created if there is a change in their health conditions.
- Once the ReSPECT process and plan is created, no new DNACPR forms should be completed for patients.

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## 1. Introduction

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express what is important to them. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them make immediate decisions about that person's care and treatment.

This policy details the standards, considerations, and procedures within Sheffield, relating to the implementation and journey of the ReSPECT plan and process including a broad range of treatment and care recommendations, particularly those relating to life sustaining treatment, including but not exclusively, cardiopulmonary resuscitation (CPR).

Many people want to be able to influence the care that they might receive and take part in recommendations about their care and treatment, whether currently in a state of ill health, or in anticipation of future ill health. For others who lack the mental capacity to participate in those conversations themselves, recommendations about the treatment that they would receive may have to be taken by others.

This policy therefore places emphasis on the need for quality discussions by clinicians with patients, as early as possible in the patient's journey. For example, this may be at the diagnosis of a long-term condition or when identified as entering last year of life, but this policy will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

Adherence to this process supports the provision of a holistic approach which involves individual assessment, assists patients to make informed decisions and voice their preferences, to maintain the patient's dignity, and respect of their free will.

## 2. What is ReSPECT?

The ReSPECT plan is an **emergency care and treatment plan which also includes recommendations about CPR.**

ReSPECT is a **process**, which aims to promote conversations between people and their clinicians encouraging high-quality, individualised, shared understanding of their care and treatment and is most relevant to those that are at risk of acute deterioration, and to promote clear documentation of such discussions and recommendations.

Advance care planning can happen at any stage and discussing what matters to a patient may lead to a ReSPECT plan being considered, discussed, and completed even in the absence of advanced illness.

This policy aims to promote emergency care and treatment planning conversations between patients and clinicians as early as possible, initiated particularly for those-

- at the onset of frailty/ageing
- at the point of a long-term condition diagnosis
- with a change/deterioration in condition
- existing co-morbidities

Resulting in more comprehensive advance care planning, clear communication and improvement in patient experience and outcomes.

Those with complex care needs and/or co-morbidities may require a detailed advance care plan to supplement the ReSPECT plan and to support in key recommendations in an emergency. Further advice on advance care planning is provided in section 9.

### 2.1 What is a ReSPECT Conversation?

ReSPECT conversations follow the ReSPECT process by discussing the following-

#### a) Treatment.

The ReSPECT process is not solely aimed at recommendations about limiting treatment; it is intended to support patients to articulate and share their views about treatments and approaches to care that they **do** want to be considered, as well as about those that they don't.

The process and plan can cover recommendations about both specific treatments (such as clinically assisted nutrition) and approaches to care (such as whether a patient would want to be taken to hospital in an emergency) with the clinician explaining sensitively advance decisions about treatments that clearly would not work in their situation.

#### b) Emergency Response

This is about discussing and reaching a shared understanding of the patient's current state of health and how it may change in the foreseeable future, identifying the patient's preferences and goals of care in the event of a future emergency and using that to record an agreed focus of care (either more towards life-sustaining treatments; more towards prioritising comfort over efforts to sustain life; or a balance between both).

#### c) Cardiopulmonary Resuscitation

This involves making and recording a shared decision about whether or not CPR is recommended. The recommendation about whether or not to initiate CPR is **one** element of emergency care and treatment plans. The ReSPECT plan is intended to extend to a wider set of clinical recommendations that can detail a planned system of proactive treatment and care and/or form part of an emergency response, in addition to recommendations regarding CPR.

The ReSPECT plan can be used in conjunction with tools that support early identification of a deteriorating patient such as the RESTORE2 Mini (Recognising when a resident may be deteriorating or at risk of physical deterioration) and NEWS2 (National Early Warning Score).

Guidance on actual completion of the plan can be found here:

[ReSPECT Resources | Sheffield HCP Website](#)

Where practicably possible, the plan should stay with the person and be immediately available to health and care professionals faced with making decisions in an emergency in which the person themselves has lost capacity to participate in a conversation about what matters to them.

ReSPECT may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, an education setting, a hospice, or a hospital. Professionals such as ambulance crews, out-of-hours doctors, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to the agreed clinical recommendations on a ReSPECT plan.

The ReSPECT plan 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 there is not a valid and applicable advance decision (ADRT) 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 include choking and a blocked tracheostomy.

## 2.2 Completion of a ReSPECT plan and record-keeping

A fundamental principle of the ReSPECT process is that the 'active' plan should accompany the patient in whatever healthcare setting they may be. Usually, this will require the patient having the plan in paper format when they are at home. A crucial aspect of ReSPECT is that it should be available and easily accessible to the relevant healthcare professionals who may have to provide care and make immediate decisions in an emergency situation.

As the ReSPECT plan is a summary of detailed conversations and planning that may have taken place on more than one occasion, it is essential that a comprehensive record of such is documented in the patient's medical record. An entry in that record should also state the date and time of completion of the ReSPECT plan.

If there is a subsequent significant change in the plan of care for a patient, a new ReSPECT plan should be completed and the old one clearly marked as cancelled and added to the patient's medical record. An entry should also be made in the patient's current health record stating the date and time that the plan has been amended or cancelled and recording details of any new plan completed. The healthcare professional completing the amendments and review is responsible for ensuring that this has been done.

The healthcare professional that has completed a ReSPECT plan for a given patient, including amending, or cancelling the plan, is responsible for ensuring adequate and timely

handover to other members of the healthcare team. This includes sharing electronically, where possible. All sharing of a patient's ReSPECT information should be documented clearly.

### 2.3 Amending or cancelling a patient's ReSPECT plan

Following the patient's journey, the plan should be reviewed and if necessary updated if and when –

- The patient's circumstances change (including what is important to them and overall health)
- They have a change in care setting\* (on admission **and** discharge from a hospital setting, admitted into a care home etc.) See below for further information.
- The responsible clinician feels it is appropriate to do so (good practice suggests every 6-12 months, or when completing medication reviews)

\*Prior to discharge, the content of the ReSPECT plan, including the recommendation about CPR, should be reviewed, discussed with the patient and recorded as such following the correct process for reviewing a ReSPECT plan.

The ReSPECT plan that accompanies the patient on discharge should be the most recent, 'active' version. The latest version of the plan must be clearly documented at discharge and be included in the patient's discharge summary and, the original copy of the plan accompanies the patient. The original copy of the plan that accompanies the patient will be known as the most up to date record of the conversation.

It will also be helpful to the health and care teams in the new setting (i.e., GP, care home) if this information includes the relevant timescale for review of the ReSPECT plan documented in section 2 of the ReSPECT plan.

The ReSPECT plan **must** be conveyed to the patient's own GP in writing as part of the discharge summary or the discharge letter (electronically where possible). Organisations are working towards this across Sheffield. Where it is not possible to share a copy of the full ReSPECT plan, relevant details must be communicated back to the patient's own GP.

**It is recommended that the GP reviews the contents of the ReSPECT plan with the individual within a reasonable timeframe to ensure it remains reflective of what is recorded as important to them as they recover post discharge and complete a new ReSPECT plan if necessary.**

A ReSPECT plan should be cancelled when its contents are no longer relevant, or no longer applicable. For example, this may be because the patient's clinical condition has changed; because they have requested cancellation; or because of a change in the assessment of the best interests of a patient who lacks capacity.

### 2.4 Best Practice and Applicability of a ReSPECT plan

A person's ReSPECT plan will remain as an up-to-date plan for emergency care and treatment until it is cancelled, or unless the decision-maker at the time has reasonable doubt that the plan is incomplete, or not applicable to the current situation. The decision-maker

should bear in mind that they should have good reason for and justify a decision to go against an existing ReSPECT plan that is complete.

If the patient, parents of the young patient or patients with parental responsibility disagree with the clinical decisions discussed during the ReSPECT conversation (such as the decision to escalate care or regarding the decisions for resuscitation) e.g. Where medical staff are strongly of the opinion that further treatment or cardiopulmonary resuscitation should not be attempted or vice versa they are entitled to request a second opinion from another ReSPECT trained clinician. Internal policy procedures will be adhered to and professional guidance sought.

When a patient has lost capacity to participate in conversations around their care and treatment, the ReSPECT plan should be used as a guide to best-interests' decision-making by healthcare professionals.

**A ReSPECT plan will be considered complete if it is either the original purple plan or printed (can be in black and white) and completed with a wet/ electronic signature, or if it is a copy (print out) of the original plan but it has been dated and signed (in section 9) to state that it remains up to date.**

It is recommended that if there is only a digital ReSPECT plan during an emergency, the clinicians providing emergency care review the digital plan and use the given recommendations to help make medical decisions when providing care, considering the date it was completed and whether it is deemed appropriate and applicable to the current situation.

### **2.5 ReSPECT for patients who lack mental capacity to discuss recommendations and plans for their care and treatment in a future emergency situation**

The ReSPECT plan may be used to document recommendations for patients who lack the mental capacity to discuss and make informed, shared decisions about their care. The Mental Capacity Act 2005 (MCA) sets out a legal framework of how to act and make decisions on behalf of patients who lack capacity to make specific decisions for themselves and applies to patients ages 16 years and over. More information on the MCA can be found here: [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://legislation.gov.uk)

Clinicians involved in the ReSPECT process should be familiar with:

- when and how to assess a patient's mental capacity
- when and how to make decisions that are in the best interests of a patient who lacks capacity
- when and how to involve advocates and proxy decision-makers in relevant decisions.

If a patient over the age of 16 lacks mental capacity to make a particular decision under the MCA, any decisions regarding their care and treatment must be made in their best interests, unless the decision is covered by a legally valid and applicable ADRT (Advance Decision to Refuse Treatment) refusing the treatment in question. *(See section 3.2 for more information)*



There must be involvement of:

- anyone named by the patient as someone to be consulted on the matter in question or on matters of that kind,
- anyone engaged in caring for the patient or interested in their welfare,
- any recipient of a lasting power of attorney for health granted by the patient, and
- any deputy appointed for the patient by the court unless it is not practicable or appropriate to consult them.

**The patient's mental capacity, lack of mental capacity, and/or the existence of a proxy decision-maker (e.g. a recipient of Lasting Power of Attorney with relevant legal powers), and/or the existence of a valid and applicable ADRT *should* be recorded in the ReSPECT plan as well as using the usual MCA documentation in line with your organisations process. Those with complex care needs may require an advance care plan to supplement the ReSPECT documentation.**

## 2.6 Roles and responsibilities for completion of the ReSPECT process

When embarking upon this process, **all** health and social care staff must:

- Have accessed relevant training and education to enable them to perform this role - this is dependent upon organisation and may include the ReSPECT training modules, profession-specific experiential learning or alternative training related to conducting difficult conversations and discussions around emergency care planning.
- Have considered and accessed the policy to clarify any concerns where relevant and/or consulted a more senior or experienced clinician/staff member.
- Respect what is important to the patient wherever possible.
- Meet the requirements of this policy, the standards, and behaviours of an employee of their organisation and of their profession.
- proactively promoting and discussing advance care planning and initiating the ReSPECT process wherever appropriate.

**In addition, trained signatories (see appendix 1) are also required to:**

- Comply with any legally binding advance refusal of treatment including cardiopulmonary resuscitation or other life sustaining treatment, as part of an existing, valid, and applicable Advance Decision to Refuse Treatment (ADRT)
- Ensure the statutory process of a best interest assessment is completed where the patient lacks capacity to be involved in the decision-making process and there is no pre-existing legally binding ADRT or specific Lasting Power of Attorney with these powers
- Discuss the benefits that are not outweighed by burdens of treatments considered
- Maintain overall responsibility for the details on the ReSPECT plan, providing signatures, and countersignatures where applicable.

Each organisation has different processes and sign off procedures. The same will apply for ReSPECT and follow your own organisation's policy; the below is for guidance.

### 2.6.1 GPs, Consultants or Doctors (with 4 years post graduate training)

In the community, the overall clinical responsibility for recommendations in relation to ReSPECT, CPR, and details on the plan lies with the GP in charge of the patient's care.

It is agreed in Sheffield that there are a number of community health care professional roles who can have the ReSPECT conversations and sign the plan as the patient's clinician, but the GP will still have overall responsibility in the community.

When a patient is **admitted** to hospital, the responsibility is above and lies with the Consultant in charge of the patient's care, until they're discharged.

The GP/Consultant may wish to delegate this responsibility to a suitably qualified clinician, see point 2.6.2.

The Consultant/GP is then responsible for reviewing and signing the ReSPECT plan as soon as possible, however Consultant/GP signature is not required to validate the document and the patient can be transferred to another care setting/ ward where the plan can be endorsed by the Consultant/GP in that setting.

### 2.6.2 Advanced Clinicians

A qualified advanced clinician for example ACP, CNS and AHPs, can be delegated the responsibility of the ReSPECT process by a GP/Consultant/Doctor (with four years post graduate training). This is dependent on their organisation's policies and the advanced clinical should be suitably qualified.

The delegated advanced clinician is then responsible for having a ReSPECT conversation with the patient (and/or family/carer where appropriate), completing and signing the plan.

The delegated advanced clinician should have received an appropriate level of training (dependent on their organisation's policies) and be comfortable, competent, and confident in undertaking the process.

## 3. Children and Young Patients

In Sheffield, most children needing palliative care are under the care of specialists in Sheffield however there may be situations when clinicians in surrounding areas need to initiate/complete the ReSPECT process.

Our local Sheffield Children's NHS Foundation Trust policy for their organisation can be found [HERE/XXX](#)

### 3.1 Who should or could initiate the discussion, and when?

It can be appropriate for professionals caring for children and young patients with life limiting or life-threatening conditions to initiate a discussion about end-of-life planning well before the

child or young patient is terminally ill. It may also be appropriate to begin discussions if a child or young patient has an acute illness or repeated illness as a result of which it becomes clearer to professionals and/or the parents that the child or young patient is moving into a terminal phase of their illness, or that they are at an increased risk of a more sudden life-threatening illness/event.

Usually, the most appropriate professional to initiate this discussion is the responsible consultant or children's palliative care practitioner. If professionals initiate a discussion, consideration should be given to the sensitive timing of this and further support for the family and young patient may be necessary.

Decision making should not be forced on a young patient or family. If a professional initiates a discussion about ReSPECT and the young patient/family indicate they do not wish to continue, their decision should be respected, and the details recorded in the medical notes.

### **3.2 Who can make decisions?**

#### **a) For children**

Parental ability to make decisions concerning a ReSPECT for their child is governed by the [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9)

Every effort should be made to communicate with the family in such a way that they can understand the information given and respond with their decision.

#### **b) For young patients**

The Department of Health (2009) state that:

*By virtue of section 8 of the Family Law Reform Act 1969, young patients aged 16 and 17 are presumed to be capable of consenting to their own medical treatment. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young patient capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent patient aged 16–17 may in certain circumstances be overridden by either a patient with parental responsibility or a court.*

In exceptional circumstances it may not be possible for all concerned to reach a united decision regarding the best interest of the young patient. If this cannot be resolved by the patient's Consultant, the Consultant should request further advice from regional experts, Medical Directors and Legal Services.

To establish whether a young patient aged 16 or 17 has the requisite capacity to consent to the proposed intervention; the same criteria should be used as for adults. If a young patient lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over (Department of Health 2009).

Where a young patient lacks capacity to decide, a person with parental responsibility for the young patient may make a ReSPECT recommendation where they consider that to be in the young patient's best interests.

If a 16 or 17 year old is capable of making an informed decision, then it is not legally necessary to obtain additional consent from a patient with parental responsibility. It is, however, good practice to involve the young patient's family in the decision-making process – unless the young patient specifically chooses to exclude them.

### **c) Children in local authority care**

Where a child is in the care of the local authority the child's social worker must be involved in all the discussions as well as parents, as the local authority shares parental responsibility with the parents. However, when a child is in voluntary care (Section 20, Children Act 1989) the parents retain full parental responsibility.

### **3.3 What happens when a young patient and a person with parental responsibility disagree about a ReSPECT recommendation?**

Decision-making with young people may be a matter of negotiation between the child, those with parental responsibility and clinicians. Inevitably there will be times when young people and those with parental responsibility for them do not agree about whether treatment and/or CPR recommendations should be made. If there is disagreement between the patient and those with parental responsibility despite attempts to reach agreement, legal advice should be sought.

### **3.4 What happens when medical staff and a young patient or person with parental responsibility disagree about a ReSPECT recommendation?**

See section 2.4.

### **3.5 Safeguarding issues**

Where there is doubt about whether a person with parental responsibility is acting in the interest of the child/young patient, then local Safeguarding Children Board procedures must be instigated.

## **4. Training and further support**

To achieve a standardised level of training across Sheffield for all health and social care partners, there is an expectation within this policy for staff to be competent and trained in relation to ReSPECT in accordance with the expectation of their role.

The training available is as follows:

### **Tier one – Basic Awareness**

As a minimum, this is aimed at **all** health and social care staff and forms part of the mandatory training to ensure staff have a general awareness of the ReSPECT process. Resources can be utilised from the Sheffield Health and Care Partnership ReSPECT website including a leaflet and watching 'Joe's story video' (6 mins).

## Tier two - Awareness and Handling Emergencies

This is aimed at staff who are directly caring for patients i.e., community nurses, practice nurses, general hospital ward nurses, and any healthcare professional in regular contact with patients who may benefit from a ReSPECT plan.

Tier two staff are expected to have completed the 'module provided by the national ReSPECT e-learning tool, with evidence recorded or the 'ReSPECT awareness' module provided by their organisations local training portal (E.g. E-LFH, ESR, PALMS).

Further research is recommended but is the individuals' choice.

## Tier three - Authorship for Conducting ReSPECT Conversations

Tier three training is aimed at staff who will be carrying out the ReSPECT conversation and completing the plan i.e., Doctors, Consultants, Advanced Clinicians (an advanced clinician is a suitably qualified clinician with the skills and ability to assess, diagnose and treat). It is the responsibility of each organisation to identify who is deemed appropriate to carry out the ReSPECT process.

The expectation is that tier 3 staff members complete **the 'ReSPECT authorship' modules provided by the E-LFH training portal.**

In addition, there must be a degree of flexibility across the system to share expertise, education and provide support in delivering additional tier three training in the plan of workshop, table -top discussion and scenario/case base learning. Organisations are encouraged to work together across the system to ensure there is no inequity in ReSPECT education and training.

The national e-learning modules can be found here: [ReSPECT \(respectprocess.org.uk\)](https://respectprocess.org.uk)

Further information and useful resources on ReSPECT can be found here:

[ReSPECT for healthcare professionals | Sheffield HCP](#)

## 5. General Principles

Variations in local policies can cause misunderstandings and can lead to distressing incidents for patients, families, and staff. Increased movement of patients and staff between different care settings makes a single, integrated, and consistent approach to this complex and sensitive area a necessity. Therefore, agreement has been reached across providers to implement a single policy which applies to **all** multidisciplinary health and social care teams involved in patient care across Sheffield.

By working together as a system, organisations collectively acknowledge and agree to adhere to, the principles of ReSPECT which revolve around a desire to ensure patients get the care and outcomes they value by:

- Encouraging patients to think about and communicate what outcomes they value and which ones they fear the most.

- Facilitating clinicians to make and record recommendations for care and treatment based on these patient preferences.
- Ensuring that these clinical recommendations are summarised in a plan for emergency care and treatment.
- Ensuring that the recommendations are recognised and respected by pre-hospital, primary and secondary care.

## **6. Commitment from Organisations**

Organisations who agree to adhere to this policy also commit to the following:

- Ensuring all appropriate staff access the most appropriate level of education and training to enable us to embed the ReSPECT process within the system.
- To raise awareness of the ethos of ReSPECT and the importance of early conversations, documenting, and sharing those outcomes and updating appropriately.
- Identify a 'ReSPECT Champion' within their own organisation to become part of a local ReSPECT Champion Network that will meet quarterly in the first 12 months following the launch. The champion will lead the drive to and further embed ReSPECT within the system.
- To ensure education and quality improvement in relation to the details on the ReSPECT plan are a priority and that concerns regarding quality are raised via an appropriate platform to allow the system to work collaboratively to resolve in a supportive manner.
- To work as one health and social care system by ensuring effective communication across organisations in relation to ReSPECT plans and shared decision making for the best interest of the patient.
- Where necessary and appropriate, carry out those difficult conversations, and provide patients with the information they need to make decisions about their care.
- Continue to explore digital options in alignment with the Sheffield Place Digital Strategy.
- Acknowledge that ReSPECT recommendations can only be effective across health and care settings if they are correctly completed and shared without delay with relevant healthcare professionals whose decisions it is intended to inform.
- Be part of the project's evaluation. Resus UK recommend a review of the effectiveness of the project's implementation is undertaken around 12 months following the launch date. Each organisation will commit to working with the lead reviewer e.g. Ageing Well lead, ICB lead to review of the implementation of the

scheme. The process and methodology will be agreed by the delivery group in the first 6 months following implementation, with learning taken from other areas, Resus UK and audit.

## **7. Organisations that agree to the principles of this policy**

- Sheffield Teaching Hospitals
- Primary Care Sheffield
- Sheffield City Council
- Sheffield Health and Social Care NHS Foundation Trust
- St Luke's Hospice, Sheffield
- Bluebell Wood Children's Hospice
- Sheffield Children's NHS Foundation Trust
- Yorkshire Ambulance Service
- Sheffield Local Medical Committee

## **8. Review**

This policy will be monitored for 12 months and reviewed as a citywide health and social care system in April 2024, with a bi-annual review thereafter.

## **9. Guidance and associated documents**

[Sheffield HCP ReSPECT Website](#)

[Decisions in relation to CPR](#)

[ReSPECT | Resuscitation Council UK](#)

[Mental Capacity Act 2005 \(legislation.gov.uk\)](#)

[Advance-Decisions-to-Refuse-Treatment-Guide.pdf \(england.nhs.uk\)](#)

[Advance care planning | End of life care | Royal College of Nursing \(rcn.org.uk\)](#)

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## 10. Glossary

<p><b>Advance Care Plan (ACP)</b></p>	<p>An Advance Care Plan is a structured documented discussion with patients and their families or carers about their wishes and thoughts for the future. It is a means of improving care for people, usually those nearing the end of life, and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. An ACP is likely to contain information about personal preferences (e.g. place of care preferences, funeral plans, understanding prognosis). An advance care plan is not a legally binding document but may contain an advance decision to refuse treatment (ADRT) which if valid and applicable is legally binding.</p>
<p><b>Advance Decision to Refuse Treatment (ADRT)</b></p>	<p>An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision you can make now to refuse a specific type of treatment at some time in the future.</p> <p>It lets your family, carers and health professionals know your wishes about refusing treatment if you're unable to make or communicate those decisions yourself.</p> <p>The treatments you're deciding to refuse must all be named in the advance decision.</p> <p>You may want to refuse a treatment in some situations, but not others. If this is the case, you need to be clear about all the circumstances in which you want to refuse this treatment.</p> <p>Deciding to refuse a treatment isn't the same as asking someone to end your life or help you end your life.</p> <p>To ensure it is valid and applicable, the document must be written formally and clearly without ambiguity. It should be signed and witnessed with regular reviews and shared with appropriate healthcare professionals involved in your care such as GP/hospital practitioners and be held in an easily accessible place in your home.</p>
<p><b>Capacity</b></p>	<p>Capacity means the ability to make and express a decision in relation to a particular matter. To have capacity a person must be able to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision and to communicate that decision (whether by talking, using sign language or any other means). If their mind is impaired or disturbed in some way, making and communicating decisions may not be possible. A person may lack capacity temporarily or permanently. However, a person should be assumed to have capacity for a decision unless or until it has been shown that they do not.</p>
<p><b>Cardiopulmonary Resuscitation (CPR)</b></p>	<p>Cardiopulmonary Resuscitation includes all the procedures, from basic first aid to advanced medical interventions, that can be used to try to restore the circulation and breathing in someone whose heart and breathing have stopped. The initial procedures usually include repeated, vigorous compression of the chest, and blowing air or oxygen into the lungs to try to</p>



	achieve some circulation and breathing until an attempt can be made to restart the heart with an electric shock (defibrillation) or other intervention.
<b>Department of Critical Care (DCC)</b>	Department of Critical Care may also be referred to as Intensive Care Unit (ICU) or Intensive Therapy Unit (ITU). This is the area in a hospital that provides sophisticated monitoring and equipment to assess and support the function of a critically ill patient's vital organs, such as the lungs or kidneys or heart and circulation (e.g. a ventilator to help with breathing) until, whenever possible, they recover.
<b>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)</b>	Do Not Attempt Cardiopulmonary Resuscitation decisions have also historically been called DNR, DNAR or 'Not for Resuscitation' (NFR) decisions or 'orders'. They refer to recommendations made and recorded that CPR is not attempted on a person should they suffer a cardiac arrest or die. The purpose of a DNACPR decision is to provide immediate guidance to health or care professionals that CPR would not be wanted by the person or would not work or be of overall benefit to that person. This tries to ensure that a person who does not want an attempt at CPR or would not benefit from it is not subjected to an attempt at CPR and deprived of a dignified death or, worse still harmed by it.
<b>Independent Mental Capacity Advocate (IMCA)</b>	<p>An IMCA is an advocate who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them. IMCAs do not make decisions and they are independent of the people who do make the decisions.</p> <p>An IMCA can support anyone who is over 16 years old and who has been assessed as 'lacking capacity'. This means they are not able to make or understand a decision about their life because the way their mind or brain works has been affected by an illness, an injury or a disability. They must have been assessed by a doctor or a social worker at the time the decision needs to be made. The person might have dementia, learning disabilities, mental health problems, a brain injury or they might have had a stroke. A lack of capacity can be temporary such as when someone has been in an accident and is unconscious</p>
<b>Lasting Power of Attorney for Health and Welfare (LPA)</b>	LPA can be given only by people aged 18 years and above. A person given this power under the Mental Capacity Act 2005, has the power and responsibility to make certain decisions on behalf of a person (the donor) if they have lost capacity to make or express those decisions. Only if an LPA gives decision-making power relating to 'health and welfare' can the attorney make decisions about a person's care and treatment. The attorney can make decisions about life-sustaining treatment such as CPR only if the LPA document states this specifically. In order to be valid, an LPA must have been registered with the Office of the Public Guardian.
<b>Mental Capacity Act (MCA)</b>	The Mental Capacity Act (MCA) is legislation designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to


	buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery.
<b>Recommended Summary Plan for Emergency Care and Treatment</b>	ReSPECT is the first nationwide approach to discussing and agreeing care and treatment recommendations to guide decision-making in the event of an emergency in which the person has lost capacity to make or express choices. This process can be used by patients and people of all ages.
<b>Resuscitation</b>	Resuscitation is general term used to describe various emergency treatments to correct life-threatening physiological disorders in a critically ill person. For example, 'fluid resuscitation' is rapid delivery of fluid into the bloodstream of a person who is critically fluid-depleted. Rapid blood transfusion for someone with severe bleeding is another example. Cardiopulmonary resuscitation (CPR) is sometimes referred to as 'resuscitation' but is a specific type of emergency treatment that is used to try to restart the heart and breathing.
<b>Supportive &amp; Palliative Care Indicators Tool (SPICT)</b>	The SPICT™ is used to help us identify people at risk of deteriorating and dying with one or multiple advanced conditions for holistic, palliative care needs assessment and care planning. It is a one paged tool. It can be used in MDT/GSF/Board Round discussions to help identify where a ReSPECT discussion may be helpful. Appendix 3.

## Appendix 1 - Training needs analysis for local adoption – Sheffield (adapted from Kent and Medway)

You may want to target initial training for staff who care for patients who have complex health needs, are likely to be nearing the end of life, or at risk of sudden deterioration or cardiac arrest.

However, all clinicians need to be aware of the ReSPECT process's role and remit and be clear on expectations in the event of a patient presenting with a ReSPECT plan.

We recommend training for all staff/levels is completed by the end of 2023, when ReSPECT should be embedded across Health and Care in Sheffield.

	Consultants, Registrars and GPs	Core medical trainees (CMTs), Foundation Year (FY1/ FY2)	Senior and specialist nurses and AHPs who want/need to be able to implement the process	Paramedics, clinical hub and Out of Hours practitioners	Nurses, AHPs and other healthcare professionals	Non-registered care assistants and support workers	Non-clinical and administrative staff *
<b>ReSPECT level 1 — Basic Awareness</b> For all staff working with patients (clinical and non-clinical) undertaken through: <ul style="list-style-type: none"> <li>Basic Awareness – What is ReSPECT leaflet</li> <li>Resuscitation Council UK Awareness video - <a href="#">Joe's ReSPECT journey – a ReSPECT explainer for people and their families - YouTube</a></li> </ul>	 Training Resource Tier 1 v2.pdf	X	X	X	X	X	X
<b>ReSPECT level 2 — Awareness and Handling Emergencies</b> For clinical staff (including non-registered staff) working in care homes, ambulance services, acute trusts, out-of-hours and community providers who will need to recognise the form and take action on the recommendations undertaken through: <ul style="list-style-type: none"> <li>E-learning as available through your organisation's training platform</li> <li>Incorporating into business-as-usual training (e.g. updates, simulations, and ongoing role essential training)**</li> </ul>		X	X	X	X	X	
<b>ReSPECT level 3 — Authorship for Conducting ReSPECT Conversations</b> For clinical staff (registered practitioners including nurse, AHP, and doctors) who will undertake the process with patients, and for any staff interested to learn more: <ul style="list-style-type: none"> <li>E-learning - <a href="https://learning.respectprocess.org.uk/">https://learning.respectprocess.org.uk/</a></li> <li>Incorporating into business-as-usual training (e.g. updates, simulations, and ongoing role essential training)**</li> </ul>		X	X	X			
<b>Optional: Advanced communication skills training</b> For clinical staff who wish to further develop their skills in enabling people to talk about and plan ahead for emergency care and treatment. Employers are responsible for ensuring their staff are adequately trained to undertake the ReSPECT process.		X	X	X			

\* It is recommended that awareness of the new plan and process is undertaken by all administrative staff involved in clinical administration including ward clerks, Emergency Department receptionists, medical secretaries, medical records staff involved in registration and clinic preparation, and relevant managers and service managers.

\*\* Business as Usual training will need to be developed with the support of Learning and Development / Medical Education as part of the Junior Doctors programme.

### Further Guidance on the Training Requirements for ReSPECT Level 3 – Conversations

Clinicians who are **experienced** in undertaking advanced care planning conversations with patients and are **confident** they possess the following core skills are not required to complete the ReSPECT e-learning, but they must ensure they are familiar with the ethos of the ReSPECT process and the local electronic form process.

CORE SKILL	Clinician Self-Assessment (Initial when achieved)
1. Can demonstrate an understanding of the ReSPECT process & how to structure ReSPECT conversations.	
2. Can demonstrate an understanding of the clinical situations covered by ‘CPR attempts recommended/not recommended’ decisions and which are not.	
3. Understands and can apply the decision making framework as described by RESUS Council UK.	
4.1 Can describe the success rates of CPR in different clinical populations and situations. 4.2 Can describe the process of CPR and post arrest care (ITU).	
5. Can explain the relevance of Mental Capacity Act, Human Rights Act and Tracey Case in relation to the ReSPECT process & CPR attempt recommendations.	
6. Has a clear understanding of ‘best interest decisions’ and what factors should be considered when making those decisions.	
7. Can demonstrate a good understanding of the ReSPECT process, including when discussions should occur and who should be involved.	
8. Has a clear knowledge of the ReSPECT plan and the responsibilities of the clinician completing the form	
9. Can demonstrate best practice in sharing information and ensuring the form is shared appropriately including providing resources for patients and family/carers.	
10. Can demonstrate self-awareness and recognise the responsibilities of the role and utilise this in practice, guided by relevant legislation, policies and guidelines.	
11. Can describe how to raise concerns appropriately (patient/family decision disunity, clinician disunity).	
12. Is an advocate for patient centred care/multidisciplinary decision making/ReSPECT process.	