Recommended Summary Plan for Emergency Care and Treatment

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Outline

- Background and development of ReSPECT to date
- ReSPECT process
- Supporting resources available
- Early feedback
- Implementation guide
- Next steps
October 2014

DNACPR from best practice to best policy and practice

http://www.journalslibrary.nihr.ac.uk/hsdr/volume-4/issue-11#abstract
DNACPR decisions and discussions have led to:

- negative patient/public perceptions
- negative clinicians’ perceptions
- complaints
- litigation
- negative media reports
Background

Common themes

• Poor or absent communication
• Bad decision-making
• Fewer forms completed
• Poor or absent documentation
Factors that confer improved outcomes related to DNACPR decisions

- Review by specialist teams at time of acute deterioration (PERRT, SPC, Elderly Care etc)
- Structured discussion at the time of acute admission
- Linking decisions related to DNACPR to overall treatment plans
- Standardised documentation for decisions
- Structured Care Planning discussions in Nursing homes

Field et al, Resuscitation, 2014;85, 1418-31
Background

National guidance on CPR decisions

“...there are clear benefits in having (CPR) decisions recorded on standard forms that are...recognised across geographical and organisational boundaries within the UK.”
but actually...
• Steering group co-chaired by RC(UK) and RCN, initiated Spring 2015
  • Wide representation – GMC, BMA, CQC, RCs, patient / public, academic institutions, clinical specialties, ambulance service etc

• Public consultation (ECTP) - Jan – Feb 2016

• Guidance / documentation amended & renamed

• Piloting (four sites) - July 2016

• NIHR funded study awarded to Warwick University – to assess effects of ReSPECT in acute settings (n=6)
• Supports a change in culture

• Alternative process for discussing, making and recording recommendations about future emergency care and treatment, including CPR

• Focuses on treatments to be considered as well as those that are not wanted or would not work

• Encourages people to plan ahead for their care in a future emergency in which they are unable to make decisions
• Is for everyone – all ages - with increasing relevance for those:
  • with particular health care needs
  • nearing the end of their lives or at risk of cardiac arrest
  • Who want to record their preferences for any reason
• Is best completed when a person is relatively well so that their preferences and agreed recommendations are known if a crisis occurs
• If an emergency occurs in someone with no ReSPECT form, consider discussing and completing it as soon as possible
• Starts with a conversation with the person
• Aims to make shared decisions whenever possible
• Establishes, by systematically work through ReSPECT:
  ▫ the background to the recommendations
  ▫ the person’s preferences for care and treatment
  ▫ agreed (whenever possible) clinical recommendations
• Page 2 confirms validity of the plan
### 5. Capacity and representation at time of completion

| Does the person have sufficient capacity to participate in making the recommendations on this plan? | Yes / No |
| Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? | Yes / No / Unknown |

If so, document details in emergency contact section below.

### 6. Involvement in making this plan

The clinician(s) signing the plan declare that these recommendations have (circle at least one):

A. Been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
B. Where appropriate, been discussed with a person holding parental responsibility
C. In the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
D. Been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If D has been circled, state valid reasons here. Document full explanation in the clinical record.

### 7. Clinicians' signatures

<table>
<thead>
<tr>
<th>Designation (grade/speciality)</th>
<th>Clinician name</th>
<th>GMC/NMC/HCPC number</th>
<th>Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

| Senior responsible clinician |

### 8. Emergency contacts

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Telephone</th>
<th>Other details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal proxy/parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/friend</td>
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<td></td>
<td></td>
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<tr>
<td>GP</td>
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<td></td>
<td></td>
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<tr>
<td>Lead Consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Review date</th>
<th>Designation (grade/speciality)</th>
<th>Clinician name</th>
<th>GMC/NMC/HCPC number</th>
<th>Signature</th>
</tr>
</thead>
</table>

|   |   |   |   |   |
Supporting documentation

- Teaching slides
- Draft policy
- Leaflet and poster
- Patient, parent, young persons information
- Clinicians guide
- Implementation plan
- Terms of use
- Public videos
ResPECT

Recommended Summary Plan for Emergency Care and Treatment

Implementation Roadmap

- Adoption
  - Formal adoption by lead group, e.g. Trust board
  - Sign up to ReSPECT terms of use
  - Understanding of ReSPECT principles and impact
  - Outline plan, risks, dependencies, resources, time scales, roles
  - ReSPECT as organisational goal with associated metrics

- Dissemination
  - Present to all clinical and organisational groups
  - Develop appropriate communications strategy building on ReSPECT materials
  - Partner organisation engagement
  - Public and patient engagement
  - DNA CPR to ReSPECT Transition engagement

- Organisational issues
  - Identify and review processes and systems impacted by ReSPECT
  - Electronic records and systems (e.g. discharge summary)
  - Resuscitation Committee/Lead agrees to ReSPECT
  - Impact on supplies for forms
  - Print and digital strategy (e.g. colour printing)

- Policy revision
  - Identify which policies need modification/replacement
  - Embed ReSPECT in existing policies
  - Transition from DNA CPR to ReSPECT (no longer separate DNA CPR)
  - Advance Care Planning
  - Capacity legislation

- Training
  - Identify training needs
  - Audit gaps in existing training to supplement/compliment
  - Use ReSPECT badge to launch training
  - Adapt mandatory training to include ReSPECT
  - Develop training plan

- Implementation
  - Agree implementation approach (full, phased, pilot)
  - Pilot testing if preferred approach
  - Detailed implementation plans
  - Transition from DNA CPR to ReSPECT
  - Implementation communications (draw on ReSPECT resources)

- Monitoring and review
  - Review feedback from staff and stakeholders
  - Feedback progress locally
  - Feedback progress to ReSPECT
  - Audit compliance/review measures
  - Incorporate feedback going forward

Implementation Roadmap adapted with permission from NIHR CLAHRC Wessex October 2016
Act & Adopt model content adapted with permission from Deciding right http://www.nescn.nhs.uk/common-themes/deciding-right/
Next steps

• Two BMJ articles
• Formation of network of organisations / communities planning to implement ReSPECT, to maximise learning and minimise duplication
• Innovative educational material development (sponsored by Macmillan)
• QI project
• Digitisation
% deaths in usual place of residence - 2011/12 - 2015/16

- England
- London
- Sussex, Surrey and Kent
- Thames Valley
- South West
- Hampshire Isle of Wight and Dorset

Location of deaths in Thames Valley, Wessex and South West
Unified DNACPR policies in UK

Scotland: yes
North East: yes
North West: yes
Yorkshire and The Humber: yes
East Midlands: yes
East of England: yes
West Midlands: yes
South Central: yes
South West: yes
London: yes
Wales: draft

END-OF-LIFE CARE

Map 67: Percentage of all deaths in an area that occurred in usual place of residence by CCG
2013

Domain 6: Ensuring that people have a positive experience of care