Using the ReSPECT emergency care and treatment plan in a community hospital: a quality improvement initiative

Christine Penhale, Catherine Evans, Lisa O'Hara and Lorraine Arnold

ABSTRACT

Background: The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a care plan to guide emergency treatment when the person cannot contribute. ReSPECT is important in supporting adults at risk of decline. Aim: To implement, evaluate and embed ReSPECT conversations to improve patient safety out of hours and support involvement of patients and their families. Methods: A quality improvement design underpinned by normalisation process theory (NPT) undertaken in a 35-bed community hospital ward between May 2022 and September 2023. Organisational prioritisation, facilitators, and champions supported the plan. Evaluation analysed ReSPECT plans, observations and a follow-up focus group. Results: ReSPECT conversations increased by 43% over 1 year (23 to 32 patients), and in quality (from 15/23 patients with a do not attempt cardiopulmonary resuscitation decision recorded and no ReSPECT plan to 32/35 with an individualised ReSPECT plan). Conclusions: ReSPECT could be implemented in community hospitals with facilitators and champions to deliver and embed change. The implementation plan is informing wider rollout across community hospital wards for adults with frailty and multiple conditions.

Key words: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) ■ Community hospitals ■ Quality improvement ■ Normalisation process theory

The approach of 'no decisions about me without me' has been a policy priority for over 10 years (Department of Health, 2010). The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plan, introduced by the Resuscitation Council UK (RCUK) in 2016 (RCUK, 2020), promotes shared decision making as a process that includes goal setting and what matters to people about their care and treatment in a potential future emergency. The patient's voice and choices, or those of their proxy decision makers, are included. The clinical recommendations ensure that there is a robust out-of-hours emergency care plan in place that goes beyond cardiopulmonary resuscitation (CPR) status (Hawkes et al, 2020). When written well, a ReSPECT plan can facilitate better decision making in an emergency, which improves patient safety out of hours, particularly in settings with no on-site medical cover, such as community hospital wards.

Community hospital wards are typically nurse-led within the multidisciplinary team (MDT). There are around 300 across the UK. They are generally small (around 30 beds), caring mainly for older adults following unplanned acute hospitalisation to support re-enablement, recovery and rehabilitation (Davidson et al, 2019). Patients frequently present with complexity, frailty and clinical uncertainty. One in four patients die within a year of admission (Evans et al, 2021). This underpins why the opportunity to open a conversation about future views and potential treatments is vital.

Patients, and family members as proxy decision makers/advocates, need time to recover from the trauma of an acute episode to participate in ReSPECT conversations, particularly for older adults with frailty who often experience marked decline following a health event (Evans et al, 2021). The palliative and end-of-life care nurse consultant for the trust spoke to a patient about her experience of a ReSPECT conversation and plan (see *Box 1*).

A qualitative study to explore the issues in discussing treatment escalation planning in people with frailty identified the term 'frailty' itself had negative connotations that many participants rejected (Lound et al, 2023). The shared understanding goal, as the antecedent for ReSPECT planning, may help to address this concern by focusing on the priorities for the person rather than deficits of frailty. Starting a ReSPECT conversation during their recovery may enable patients to share insights and express their views and wishes regarding potential future emergencies. The Parliamentary and Health Service Ombudsman report, *End of Life Care: Improving do not attempt CPR conversations for everyone* (2024) found that

Christine Penhale, ReSPECT Lead, Sussex Community NHS Foundation Trust, christine.penhale@nhs.net

Catherine Evans, Honorary Nurse Consultant and Professor in Palliative Care, Joint post between Sussex Community NHS Foundation Trust and King's College London

Lisa O'Hara, Nurse Consultant Palliative & End of Life Care, Sussex Community NHS Foundation Trust

Lorraine Arnold, Matron, Intermediate Care Unit, Sussex Community NHS Foundation Trust

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conversations often happen too late and in emergency settings. It advocates a better balance, with earlier planning in non-emergency settings where possible.

Perkins et al (2022) discussed the challenges of comprehending risk and benefit while focused on surviving the acute episode. Acute clinicians spoke about the difficulty of making emergency treatment recommendations that are useful in all settings. Clinicians in the acute setting are often less clear in their communication about risk versus benefit of treatments. Coupled with minimal previous knowledge or relationship with the patient, and time constraints, this can contribute to burdensome and futile treatments with bias towards extending life over quality of life.

An analysis of case studies across multiple acute hospitals found themes of avoidance of ReSPECT conversations due to competing demands, lack of confidence in how to broach the subject, and waiting for the elusive 'window' of opportunity (Eli et al, 2022). Much of the work in community hospital wards is parallel planning – supporting recovery while anticipating and planning for continued decline. This reflects the uncertain trajectory for patients with frailty and multiple conditions.

Escalation plans from the acute setting are often limited to a resuscitation status only, or a ReSPECT plan that is neither personalised nor fit for purpose to inform care supporting recovery or anticipating, and planning for risk of continued decline. This is particularly problematic for clinical decision making in community hospital wards during out-of-hours periods (weekends and at night) with reduced availability of doctors or advanced clinical practitioners. Although ReSPECT is used nationally across care settings and advocated for patients at risk of decline (Pitcher et al, 2017) there is little understanding to inform implementation and embed in routine clinical care.

Aim

The authors' aim was to implement, evaluate and embed early ReSPECT conversations in a community hospital ward to improve patient safety out of hours and support involvement of patients and their families. The implementation plan intended to facilitate a multiprofessional approach to the ReSPECT process, led by the senior nursing team.

Methods

Study design

A quality improvement (QI) project underpinned by normalisation process theory (NPT) (Murray et al, 2010) as a conceptual framework was used to explore the complex process of implementing, evaluating, and embedding ReSPECT within the community hospital ward. NPT proposes different kinds of work that people undertake to implement and 'normalise' a new practice in routine care. This is detailed as four constructs of: coherence, cognitive participation, collective action and reflexive monitoring (see *Table 1*).

NPT is useful as it focuses on the things people do rather than their attitudes or beliefs, enabling them to embed new ways of working into their routine everyday clinical work (Murray et al, 2010; Lund et al, 2015). The NPT constructs informed the method of data collection, including the focus group questions and observations, data analysis and interpretation.

Box 1. Case study: nurse consultant and patient experience feedback

The nurse consultant for palliative and end-of-life care spoke to a patient on the community hospital ward about her experience of ReSPECT. She was an 87-year-old admitted for rehabilitation, following a fractured neck of femur operation. She had a red-bordered do not attempt cardiopulmonary resuscitation (DNACPR) form written while in the acute hospital that stated 'not for resuscitation'.

A ReSPECT conversation was offered as part of her admission process to the community hospital by a doctor and a ReSPECT leaflet was given to her prior to the conversation. She then had a personalised ReSPECT plan, her feedback was:

'When I was in hospital, they told me that I wouldn't survive if my heart stopped, and they wrote a red form.

'Whilst I was in hospital, they did some scans and they found a lump in my abdomen which is cancerous. I knew immediately what I would want to do in the worst-case scenario but had no one to tell or write it down, so I have been carrying this round with me ever since not quite knowing who to tell or what to do. When the doctor offered me this conversation I was so pleased as I thought this is where I can tell them what I want. He asked me what was most important to me and what I would want in an emergency, and I told him. It's now written down in a document I can show my children, and everyone knows what I want.

'I feel I don't have to carry all that round with me anymore, I feel like a weight has been lifted off my shoulders.

'Thank you for asking me what matters to me and what I want.'

Table 1. Normalisation theory constructs

Normalisation process theory	
Coherence	The work people do to make sense of a new intervention
Cognitive participation	The work people do to engage with a new intervention
Collective action	The work people do to enact a new intervention
Reflexive monitoring	The work people do to appraise a new intervention

Source: Murray et al, 2010

Setting

This was a 35-bed mixed sex community hospital ward, serving an urban community in south-east England of approximately 1.3 million population. The unit is the largest of the 11 wards located in the community NHS foundation trust. Patients admitted to the ward are mainly older adults with multiple conditions in transition between hospital and home (including care home) following typically an unplanned acute hospitalisation. The ward had reported clinical incidents with escalation decisions sending patients back to the acute hospital being suboptimal. These resulted in burdensome transitions for the patients, with often little clinical benefit, with patients transitioning back to the community hospital ward without further intervention. The implementation of ReSPECT was an organisational and commissioning priority, aligned with national priority for documentation of care plans in an emergency to optimise care delivery at points of patient decline. (Perkins et al, 2022).

Box 2. ReSPECT audit checklist

Are the following recorded:

- Preferred name
- Summary of relevant information (diagnoses, communication)
- Details of other relevant planning documents
- Legal proxy information
- Continuum (personal preferences)
- What is valued/feared
- Clinical recommendations
- CPR status
- Capacity assessment
- Involvement in making ReSPECT plan.
- Designation
- Clinician name
- Registrant number
- Signature
- Date and time
- Emergency contacts and others

Are all entries in a language that can be easily understood by the patient and other health care practitioners?

Source: adapted from information in the Resuscitation Council UK ReSPECT resource package sent out to registered organisations

Box 3. Focus group topic guide informed by normalisation process theory constructs

Coherence
- What were the barriers that you had at the beginning to having those ReSPECT conversations with patients?
- What was the culture of the ward about ReSPECT planning, whose business was it?
- How did you make sense of what your role is and were the ReSPECT plans that were in place before you started the quality improvement project helpful?

Cognitive participation
- The 'buying in' how did you change your minds from 'This is too hard' to 'This is actually part of my role; I can do this'?

Collective action
- What would you say worked and what would you say make sure you do that?
- Can you share how you shifted the culture of ReSPECT from being the domain of the doctor/advanced nurse practitioner?

Reflexive monitoring
- What now?
- How do you maintain the momentum?
- What next to be even better?

Participants

Participants were all nurses and doctors delivering care within the community hospital ward.

Implementation plan for ReSPECT

The plan comprised three main components:

- Multidisciplinary approach. 'Normalising' ReSPECT into the nurses' routine care provision using additional coaching and support from the matron and the advanced nurse practitioner (ANP) in the clinical setting, within the MDT
- Training. The NHS trust required registered nurses (Agenda for Change, band 6 and above) to complete mandatory level 2 authorship training on facilitation and documentation of ReSPECT conversations and plans with patients (and families when applicable). Staff had attended training previously, but never been involved with the ReSPECT process
- Support in practice. The ReSPECT lead (a senior nurse highly experienced in acute and community settings, with a background of leading a resuscitation team and delivering cardiopulmonary resuscitation (CPR) decision making and communication skills education) and a nurse consultant in palliative and end-of-life care undertook an initial visit to the community hospital ward to gain a baseline and understand the challenges the team had in implementing ReSPECT conversations into their practice. There were further on-site visits once the QI project was underway to champion and encourage the team to maintain progress.

Data collection

Data collection was undertaken at baseline and follow-up to review embedding in routine care.

Baseline data collection involved three steps:

- Step 1: initial baseline audit on use and quality of ReSPECT plans in the community hospital ward extracted from the electronic patient record (EPR) in May 2022. Audit items were informed by information the Resuscitation Council UK shared with provider organisations following ReSPECT implementation
- Step 2: case note review with data extracted from the EPR on the quantity and quality of ReSPECT plans. This review looked at whether there had been completion of all fields in the ReSPECT plan, noting goal setting, personalisation of the plan and realistic clinical interventions. The ReSPECT plans were reviewed in detail, individualised feedback given, and key points shared with the whole team. The ReSPECT plans were evaluated using the Resuscitation Council UK ReSPECT adapted audit checklist (see *Box 2*), with additional qualitative review of the clinical recommendations
- Step 3: observations of staff in the community hospital ward by the ward matron who made detailed in field notes.

Follow-up data collection

A focus group was undertaken 6 months post-implementation to evaluate the effectiveness of the ReSPECT QI project. The topic guide was informed by the NPT constructs (see *Box 3*). The focus group was led by the first author (CP) (an experienced focus group facilitator), digitally recorded, and transcribed verbatim by CP.

Data analysis

Data analysis for the audit data involved descriptive statistical analysis. The narrative data from the case notes review and focus group used framework analysis (Ritchie and Spencer, 1994). The NPT informed the initial framework for the data analysis. Data were deductively coded using the framework, and inductive codes generated when required for data outside of the framework. This framework method of thematic analysis

Table 2. Changes over time in number of ReSPECT plans, quality improvement actions and quality assessment

Date	Number of patients and ReSPECT plans	Quality improvement (QI) actions and quality assessment of the ReSPECT plans with individualised feedback
May 2022	*N*=23 patients 15 had a DNACPR (65%) 0 had ReSPECT plans 1 in the ReSPECT template on the electronic patient record but not visible in the patient record, meaning unlikely to be used in clinical care, potentially leading to inappropriate clinical interventions	1. SystmOne on the electronic patient record to be the only way to record ReSPECT plans 2. Print ReSPECT plan in colour, double-sided to be viewed at the bedside 3. Need to eradicate potential risks associated with ReSPECT plans stored away from the bedside 4. Staff training on ReSPECT: 17 of the multidisciplinary team (MDT) trained in ReSPECT level 2 5. Interdisciplinary face-to-face consolidation at the bedside by the ReSPECT lead and nurse consultant for palliative and end of life care 6. Ongoing formal training of new staff or staff who needed to repeat training 7. Work as an interdisciplinary team to improve the completion and sharing of ReSPECT plans 8. Embed the offering of ReSPECT leaflet/conversation into initial patient assessment after admission
September 2022	*N*=35 patients 17 ReSPECT plans	1. Engagement, and support from the ReSPECT lead (CP) **Quality assessment of ReSPECT plans:** ■ 4 needing remedial action, eg detail adding to clinical recommendations ■ 2 in the ReSPECT template on the electronic patient record and not visible in the patient record, meaning unlikely to be used in clinical care, potentially leading to inappropriate clinical interventions ■ 11 with process issues needing attention eg signatures missing
June 2023	*N*=30 patients 23 ReSPECT plans	1. Appointment of new matron, engagement, and support from the ReSPECT lead (CP) **Quality assessment of ReSPECT plans:** ■ Development programme and support in practice delivered by Matron and ANP, involving role modelling and shadowing in the MDT and family meetings. ■ ReSPECT workshops delivered in practice setting by the matron and ANP ● 7 patients no ReSPECT plan ● 22 plans needing amending/ sharing to implement in clinical care ● 1 excellent, all fields complete with realistic personalised recommendations
August 2023	*N*=35 patients 32 ReSPECT plans	1. Matron acts as a champion for implementation of ReSPECT, providing clinical nursing leadership within the multidisciplinary team, supported by the ReSPECT lead (CP) **Quality assessment of ReSPECT plans:** ■ Minor process issues with 4 ReSPECT plans ■ Excellent improvement with content, documentation and sharing ■ Evidence of multiprofessional input

allowed for pursuit of themes on implementation in relation to the respective NPT constructs. The focus group recording was transcribed verbatim. Focus groups and observations were analysed using NPT and focused semi-structured questions (see *Box 3*) using paper and highlighter pens. Analysis was undertaken by the ReSPECT lead using the NPT constructs, The interpretation was validated by the matron, who co-facilitated and the nurse consultant for palliative and end-of-life care.

Ethical considerations

Ethical approval was not required for this quality improvement initiative. Verbal consent to record and analyse the focus group was gained. The nurses' responses were anonymised.

Results

Baseline to 12 months:

At baseline (May 2022), none of the 23 patients in the community hospital at that time had a care document for use in an emergency. Plans were limited to resuscitation status only. Plans were documented on paper held in a central folder, not with the patient record. Initial actions were agreed and sent to the whole team, including documentation on the EPR only (SystmOne), printing a bedside ReSPECT plan and training on ReSPECT for registered nurses. The ReSPECT plans improved over time; consistently had a goal documented, became increasingly personalised with more realistic clinical recommendations over 12 months to June 2023, with monitoring of sustainment completed until August 2023 (see *Table 2*).

Table 3. Roles and responsibilities of team members and participants in the focus group February 2024 (*N*=9)

Role and responsibility	Participant numbers
Band 6 senior staff nurse Introducing ReSPECT to patients and involved with completion of ReSPECT plans	6
Band 7 ward manager Accountable for ward progress	1
Band 8a advanced nurse practitioner 'In place' coach and experienced ReSPECT author	1
Band 8a ward matron Overall clinical lead	1

Evaluation of change

Over the first 12 months of implementation (May 2022 to June 2023), improvement in the quality of the ReSPECT plans was minimal. For example, in June 2023, only 1/23 plans were assessed as excellent (see *Table 2*). Until June 2023, the ward nurses relied on the ANP and the doctor to undertake ReSPECT conversations, seeing these professionals as most competent to complete the ReSPECT process. The appointment of a new matron in June 2023, led to better engagement and understanding of the organisation culture that was inhibiting the implementation of the ReSPECT process. Monitoring until end of August 2023 demonstrated both an increase in the number and quality of the ReSPECT plans. The new matron facilitated a shift of stance for the nursing staff to see the importance of their role, and competency to initiate the ReSPECT process. This renewed energy and enthusiasm enhanced the chance of successful implementation. The ReSPECT plans moved from little more than DNACPR recommendations in a different format, to plans that represented patients' views and wishes, with helpful clinical recommendations.

The authors found that the ReSPECT conversation and plan, while important in the community hospital setting, did not provide clear clinical recommendations in the 'transition phase' when patients were at risk of acute deterioration following admission to the community hospital ward. This was an unexpected finding, as the authors thought the clinical recommendations within the ReSPECT plan would suffice. This informed the development of a Treatment Escalation Plan (TEP) to give granular detail to support clinical decision making alongside a ReSPECT plan. The ReSPECT plans were reviewed before discharge to, for example, the patient's home or care home. This intended to ensure the clinical recommendations were up to date to maintain continuity of care in the patient's priorities for care and treatment at, for example, point of deterioration.

Embedding change

Embedding the ReSPECT process began in June 2023, with detailed evaluations until August 2023, and follow-up after 6-months with a focus group in February 2024. The newly appointed matron identified barriers to the nursing participation in the ReSPECT process, including low contribution in MDT meetings.

These challenges were addressed with solutions targeting nursing competencies and strengthening the nurse-led culture, and opportunities to support the implementation plan. Four main themes were pursued in the data informed by the NPT four constructs.

Focus group findings

Understanding of embedding ReSPECT involved observations in practice and a focus group. NPT informed the focus group topic guide (see *Box 2*) to gain evaluative insight from the senior nursing team on embedding change in practice, informing the implementation plan for wider rollout, and perceptions of benefit. Focus group findings are categorised under the NPT topics, with themes exemplified by a quote.

Coherence: 'When a patient has a ReSPECT plan, you know exactly what to do'

The team (see *Table 3*) needed to understand what their specific tasks and responsibilities were. This enabled them to become more equal partners with the doctor and the ANP, and work in a more interdisciplinary way.

The matron undertook a development programme with the band 6 nurses to empower them to integrate ReSPECT conversations into their practice. A programme of shadowing and role-modelling ReSPECT conversations was facilitated by the matron, ward manager and ANP. The band 6 team repeated the ReSPECT level 2 training and completed their competencies. ReSPECT was added to the daily safety huddle and ReSPECT leaflets were offered to patients on admission. A ReSPECT review was added to the weekly MDT meeting. The band 6 nurses undertook a weekly review of ReSPECT progress to share responsibility and offer each other support when needed.

The nine focus group participants were the ICU ward matron, ward manager (band 7), six registered nurses (band 6) and the ANP (band 8a). It lasted 2 hours. The focus group demonstrated understanding of the importance of ReSPECT conversations and plans, recognising that patients in the community hospital ward setting were vulnerable to re-admission to the acute hospital and benefit from an opportunity to discuss resuscitation. They acknowledged that patients are often scared.

Two participants commented:

> **'They are evolving and improving. We still need to think about escalation plans while they are with us. We have a lot of patients and you do feel when they've made it to rehab, they've gone through a horrible experience and then it is scary for them to suddenly start talking about resuscitation.'**

> **'We find that we are getting patients that are not going to be doing very well. And then you have the conversation that they don't want to be resuscitated**

but how many times do they bounce in and out of the acute [hospital] before that happens? We don't want to depress them of course they're still having treatment for reversible things, antibiotics etc.'

Cognitive participation: 'Understanding responsibilities to foster interdisciplinary working'

The relationship between all the senior team had improved and they were working collectively and were all expected to make a valid contribution. Clinical supervision was given to discuss ReSPECT conversations and offer suggestions about how to improve. The focus group participants were able to see the benefit of having a plan that supported their decision making out of hours. The participants felt their contribution was valid, as they had moved from gathering information to being able to complete ReSPECT plans as equal partners within the multidisciplinary team. One participant said:

'Where I used to work before, it was only the doctors. It is important, there are people who aren't allowed to do things that they are competent to do. Often, they would be sent out to gather the information, but wouldn't be allowed to sign the plan, and they felt like that was a cheat because I'm the one who's done the hard work sort of thing.'

Collective action: 'Changing the culture for interdisciplinary working in advance clinical decision making'

As the nurses' confidence improved, they became more involved and were proactive about the conversations they were having. They established what was expected, they would review any newly admitted patients and ensure they had been given a ReSPECT leaflet as part of the welcome meeting. They planned an initial conversation and completed the ReSPECT plan. If a patient's situation was more complex, they brought that information back to the MDT for further discussion. Following support from the ReSPECT lead, this built their confidence in completing the plans on the system and asking for feedback on how they could improve. The focus group findings identified how the MDT and family meetings provided support for the more complex patients. The nurses found the role modelling by the senior clinical ANP in the MDT meeting and inclusion into these meetings invaluable. One participants said:

'The trickier ones we discuss at the MDT meeting, and I do that. And then when things do change, we've got the plans there started. If things change (maybe following a family meeting) then the ReSPECT plan gets updated. So, by the time they go home, it might look quite different.'

Reflexive monitoring: 'We worked on a lot of things to improve practice and nurse-leadership within the multidisciplinary team'

The nursing team were able to see how patients had benefited from the improvement in the wider provision of offering an opportunity to discuss and complete a ReSPECT plan. The nurses had grown in confidence to introduce, offer and complete a ReSPECT plan with a patient and/or the family. The positive feedback for the ward from the ReSPECT lead about the increasing quality of the personalised information detailed in ReSPECT plans encouraged them and supported their growth in confidence. The nurses' felt safer in their practice, knowing there was a plan in place with clear detail on the patient's preferences in an emergency and on management detailed in the clinical recommendations and treatment escalation plan, if in place. This was particularly important for clinical decision making at weekends with reduced access to ANPs and the doctors.

The focus group findings indicated the requirement for both formal training on ReSPECT to increase their knowledge and consolidation in practice with individual feedback with the ReSPECT lead about initiating conversations and reviewing ReSPECT plans. The workshops led by the ward matron on ReSPECT had increased their confidence and provided opportunities for shared learning. The nurses acknowledged feeling safer in their clinical decision making and a sense of pride in their achievements in improving the quality of patient care.

'The training has great impact on our knowledge and the individual feedback and whatever we need to improve, which helped. We gained confidence with the ANP, and we started completing ReSPECT plans. The weekly ReSPECT reviews that we do in the MDT [meetings and] the band 6 workshops helped develop skills and confidence by having this space to feel safe as a little group of all the same level.'

'We document them in one or two days. Clear plan, what to do, escalation about everything. They don't need to go to the handover sheet it will be clearly documented on the ReSPECT. I think we have come a long way.'

Discussion

The authors found the community hospital ward setting facilitated a multiprofessional approach to ReSPECT when led by a senior nursing team and embedded into MDT meetings. Family meetings were beneficial when patients lacked capacity to be fully involved with the ReSPECT plan. Nurses became more confident at broaching the 'what next' opportunistic questions with patients. The findings have implications across inpatient care settings to support implementation of ReSPECT plans for older adults with multiple conditions, including those with cognitive impairment, and their families.

Key requirements to support implementation focused on three fundamental areas: an MDT approach, opportunistic conversations, and organisation culture.

MDT approach to ReSPECT planning

The findings indicated an initial culture of deference to medical staff and advanced nurse practitioners from the senior nurses on the ward. Supported by further visits from ReSPECT lead

KEY POINTS

- The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process supports person-centred conversations planning for future emergency care
- Implementing ReSPECT is complex and requires interactional work with health professionals
- A multidisciplinary team approach could support and enhance the ReSPECT process

and the palliative and endoflife care nurse consultant and the matron facilitating ReSPECT conversation rehearsals, the implementation plan evolved, leading to key recommendations for wider implementation of ReSPECT across all community hospital ward settings in the NHS trust. A key finding on successful implementation of individualised ReSPECT plans was the integration of discussing and reviewing ReSPECT plans in the weekly MDT meetings. This fostered a culture of interdisciplinary working. This approach played a significant role in facilitating and supporting ReSPECT conversations and translating them into action. The MDT approach encourages those who know the person best to contribute to the plan and empowers all staff to integrate ReSPECT conversations into their practice (Hawkes et al, 2020; Kesten et al, 2022) Both the ReSPECT plans and treatment escalation plans are now discussed in weekly MDT meetings. The benefit in this setting is the inclusion of the ward doctor/ ANP, experienced physiotherapists, occupational therapists and senior nurses (Huxley et al, 2021).

The weekly MDT forum enabled staff to share their experiences in undertaking ReSPECT conversations and provided senior support from the ANP and doctors. This was important when often these conversations are perceived as emotionally difficult and are deferred to a doctor who may struggle to find the right time or location or talk about, for example CPR status, when prognosis is uncertain (Hartanto et al, 2023).

Lund et al (2015) used NPT to undertake an explanatory systematic review of qualitative implementation studies focusing on the barriers and facilitators to advance care planning. It concluded that incorporating ways of working that integrate important conversations across the multidisciplinary team is more likely to succeed than unsustainable solutions such as a uni-disciplinary approach of advanced clinical practitioners solely undertaking advance care planning conversations.

Opportunistic conversations

The rehabilitation phase in a patient's journey provides an opportunity to start ReSPECT conversations to enable the patient's voice and choices (where possible) to be considered. The emergency care planning approach in the acute setting is often 'blunt' and misunderstood by families involved with best interests' decisions. This can lead to alienation between families and health professionals. (Islam et al, 2023). Timing of the ReSPECT conversation is often better received when the person is relatively well (Pitcher et al, 2017).

There is an opportunity to broaden the conversations started in the acute hospital setting to include more likely emergency treatment options. There is widespread confusion among lay people regarding the likelihood of succumbing to a sudden cardiorespiratory arrest, what is involved treatment and the efficacy of CPR (Levinson et al, 2017).

Patients with uncertain trajectories such as those with chronic long-term conditions are less likely to be offered the opportunity to have advance care planning conversations. Added to this, the emotionally complex conversations when the outcomes are unpredictable can be burdensome for staff (Lund et al, 2015). The authors found that this was an inhibiting factor, with the nurses and doctors unsure about how to open the ReSPECT conversation.

In 2016 a national cohort study (Evans et al, 2021) found that adults admitted to inpatient community hospital wards had increased frailty, complexity, and uncertainty than previous cohorts who required rehabilitation and were expected to recover. One in four patients had died within 1 year of discharge. Therefore, a move towards a more palliative model, including a comprehensive geriatric assessment and planning for end of life care was proposed. The addition of a ReSPECT conversation that may lead to an emergency care plan would add an additional safety net for these vulnerable patients.

Organisational culture

Nurses who had received the ReSPECT level 2 training, additional resources and follow-up support found initiating the ReSPECT process difficult. They lacked self-confidence to share their opinions or take responsibility for ReSPECT facilitation. The authors observed and heard about a culture of hierarchy while visiting and spending time with staff. The default position was to defer to the ward doctor or advanced nurse practitioner, where available. There was a perceived power imbalance between health professionals; this has been noted elsewhere. The goal of multiprofessional working is collaboration and supportive interprofessional challenge to enhance the quality of care planning. This can be improved by empowering the senior nursing staff to contribute to the ReSPECT process (Lockhart-Wood, 2000) The traditional model of placing the power for decision making for people who lack capacity to be involved with the doctor limits the involvement of those who know the person best (O'Donnell et al, 2023).

Strengths and limitations

A strength of this QI project was the overall shift of responsibility and ownership of the ReSPECT process from a predominant doctor/ANP role to a whole-team approach. Another was the recognition of the community hospital setting being potentially the right time and right place for ReSPECT conversations to take place. A limitation of this QI project is the potential bias because the QI lead was also the ReSPECT lead. This was mitigated by the team approach, with the nurse consultant and ward team reviewing and contributing to the interpretation of the findings. The changes observed may be the individual culture and leadership on the chosen ward, the need to identify

and support growth in the subsequent wards during rollout will be crucial.

Conclusion

When patients are admitted to community hospital wards, this may prove to be the right time and place to initiate ReSPECT conversations. Admittance to the community hospital ward provides an important opportunity to review the clinical recommendations from the acute hospital setting, improve patients' shared understanding of them and ensure that the ReSPECT plan supports their next steps. The ReSPECT conversations give patients the opportunity to ask questions about the clinical treatments and their limitations carried out during their acute episode of care. The addition of a treatment escalation plan added additional safety during out-of-hours periods when there is no medical cover for those at risk of deterioration and potential re-admission to the acute hospital. Integration of ReSPECT conversations into everyday practice is complex and can be enhanced by education, support in practice and a multiprofessional approach. Further research into patients' and their families' (if relevant) lived experience of having a ReSPECT conversation and plan would enhance understanding of how best to broach the subject, and what may cause distress. **BJN**

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CPD reflective questions

- Think about how you could open conversations about ReSPECT plans with patients under your care
- Find out more about the ReSPECT process and access ReSPECT education
- Consider whether you could apply normalisation process theory to embed a new process or way of working into your everyday work