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The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process: An Audit of Its Utilisation on a UK Tertiary Specialist Intensive Care Unit

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Abstract : Introduction: The ReSPECT process supports healthcare professionals when making patient-centered decisions in the event of an emergency. It has been widely adopted by the NHS in England and allows patients to express thoughts and wishes about treatments and outcomes that they consider acceptable. It includes (but is not limited to) cardiopulmonary resuscitation decisions. ReSPECT conversations should ideally occur prior to ICU admission and should be documented in the eight sections of the nationally-standardised ReSPECT form. This audit evaluated the use of ReSPECT on a busy cardiothoracic ICU in an NHS Trust where established policies advocating its use exist. Methods: This audit was a retrospective review of ReSPECT forms for a sample of high-risk patients admitted to ICU at the Royal Papworth Hospital between January 2021 and March 2022. Patients all received one of the following interventions: Veno-Venous Extra-Corporeal Membrane Oxygenation (VV-ECMO) for severe respiratory failure (retrieved via the national ECMO service); cardiac or pulmonary transplantation-related surgical procedures (including organ transplants and Ventricular Assist Device (VAD) implantation); or elective non-transplant cardiac surgery. The quality of documentation on ReSPECT forms was evaluated using national standards and a graded ranking tool devised by the authors which was used to assess narrative aspects of the forms. Quality was ranked as A (excellent) to D (poor). Results: Of 230 patients (74 VV-ECMO, 104 transplant, 52 elective non-transplant surgery), 43 (18.7%) had a ReSPECT form and only one (0.43%) patient had a ReSPECT form completed prior to ICU admission. Of the 43 forms completed, 38 (88.4%) were completed due to the commencement of End of Life (EoL) care. No non-transplant surgical patients included in the audit had a ReSPECT form. There was documentation of balance of care (section 4a), CPR status (section 4c), capacity assessment (section 5), and patient involvement in completing the form (section 6a) on all 43 forms. Of the 34 patients assessed as lacking capacity to make decisions, only 22 (64.7%) had reasons documented. Other sections were variably completed; 29 (67.4%) forms had relevant background information included to a good standard (section 2a). Clinical guidance for the patient (section 4b) was given in 25 (58.1%), of which 11 stated the rationale that underpinned it. Seven forms (16.3%) contained information in an inappropriate section. In a comparison of ReSPECT forms completed ahead of an EoL trigger with those completed when EoL care began, there was a higher number of entries in section 3 (considering patient's values/fears) that were assessed at grades A-B in the former group ($p = 0.014$), suggesting higher quality. Similarly, forms from the transplant group contained higher quality information in section 3 than those from the VV-ECMO group ($p = 0.0005$). Conclusions: Utilisation of the ReSPECT process in high-risk patients is yet to be well-adopted in this trust. Teams who meet patients before hospital admission for transplant or high-risk surgery should be encouraged to engage with the ReSPECT process at this point in the patient's journey. VV-ECMO retrieval teams should consider ReSPECT conversations with patients' relatives at the time of retrieval.

Keywords : audit, critical care, end of life, ICU, ReSPECT, resuscitation
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