One Gloucestershire
Transforming Care, Transforming Communities

ReSPECT

Key facts about using ReSPECT

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is **guidance** which can be used to inform decision making in an emergency. It may include recommendations about CPR (cardiopulmonary resuscitation).

The ReSPECT form is a person held document and the **original** document should follow the patient **at all times**. at home, in hospital, consider taking to important clinic appointments etc. Copies may be kept by the hospital, GP, care home, family etc. Ask if the ReSPECT form is with the person, Check on Summary Care Record if one has been coded.

Forms may not be fully completed – the ReSPECT process can take a number of conversations and so in the event of unexpected emergency/deterioration, use information provided to inform decision making. Even if the information relates to a different setting, **Ask** what has changed and **Check** what is still applicable and what needs to be updated.

The absence of a Lead Clinician signature e.g. GP or Consultant does not automatically invalidate a form as many members of the MDT can contribute to ReSPECT guidance. **Ask** to see the form and **Check** how you can use the information to provide the most appropriate care for the individual.

Top tips for completing ReSPECT

1. Always **Ask** and **Check** the contents of the document when someone changes care location – review/update **before** transferring care.
2. Write plenty of details in the 'patient's priorities' box. It is impossible to cover every possibility in the 'recommendations' box but knowing what matters to the person can help a health care professional make a decision in an emergency.
3. The guidance on the form should be written to support the next care provider/professional to review the form. Think about who that might be - paramedic/care home staff and what advice would help them in clinical decision making:
   - If patient leaving hospital for community setting, guidance should consider whether referral back to acute hospital is appropriate/care focused in the community and admission avoidance/ treatments which may help and those which may have been declined.
   - Try to be specific, not give vague statements and add rationale for recommendations. Consider frailty score/performance status but not appropriate for chronic physical or learning disability/autism.
   - Consider subheadings e.g. interventions to be considered/ interventions to be avoided/ recommended location for care.
   - Highlight additional sources of advice e.g. Cinapsis/Palliative care telephone advice service/ Frailty team. You can add another piece of paper if needed!

Please see examples opposite.

What to write on the ReSPECT form

Some useful phrases/ways of documenting priorities and recommendations:

Patient Priorities

- I value time with my family and want to live as long as possible.
- Comfort and avoiding time in hospital is my priority.
- I fear being dependent on others and would not wish to be alive in this state.
- I would not wish to die in hospital, being at home is very important for me.

Clinical Recommendations

Useful Phrases:

- Referral to acute hospital for escalation of care for all conditions is appropriate.
- For active management of acute events including consideration of non-invasive ventilation/oxygen and antibiotics but would not be for an attempt at CPR.
- For all interventions available in the community setting including rapid response referral – escalation to secondary care can be considered if not improving.
- Consider IV antibiotics via rapid response – this represents ceiling of treatment and if deteriorates despite this, focus on comfort measures only.
- Admission to the acute hospital is not felt likely to alter care/management/patient outcome. Optimize care with admission to hospital only to be considered if symptoms are unmanageable in the community.
- XXX would wish to remain in their own home and avoid hospital. They are prone to falls and if a fracture or severe head injury is suspected, admission to hospital may be appropriate with a view to returning home ASAP. Consider a period of observation and GP review prior to transfer to hospital. May be appropriate to keep at home and make comfortable overnight so that a plan can be made with the Frailty team/palliative care team/ patient's regular GP during office hours.
- Long-standing respiratory illness. Whilst being at home is valued, feels a sense of safety and reassurance in being in a hospital environment. Dying in hospital would not be unacceptable outcome and may be preferred location for admission even with a focus on purely symptomatic care.
- XXX wishes to be at home as much as possible and preferred place of death is home. Would consider hospital admission if there is a reversible cause for any deterioration in condition which cannot be managed in the community. Ceiling of hospital treatment is ward based treatment.

Less useful phrases:

- Ward based care (especially when present on a form in a community setting but still quite vague in hospital setting).
- For full active management.
- Not for hospital treatment unless necessary.
- There may be some benefit from hospital admission in some situations.