One Gloucestershire
Transforming Care, Transforming Communities

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

Policy template for use across all providers in Gloucestershire

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1. Policy Summary

ReSPECT stands for:

Recommended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment.

ReSPECT is a process which involves determining a patient's beliefs, values and fears and a picture of their current life situation. This information is clearly summarised and documented to create a ReSPECT plan including recommendations and information that can inform and guide healthcare professionals to provide individualised, personalised care and treatment in an emergency situation.

The process is intended to respect both individual preferences and clinical judgement and may be used to avoid repeatedly revisiting potentially upsetting topics and to assist conversations regarding future care and treatment by providing a clear summary, or when someone no longer has capacity.

It is never too early to initiate a ReSPECT conversation as, by definition, emergencies are unpredictable.

This document outlines the One Gloucestershire policy covering the ReSPECT process for patients of all ages.

Throughout this policy, individuals will be referred to as patients.

Each organisation will outline role, responsibilities and training requirements responsibilities given the breadth of staff groups.

The ReSPECT process will remain active across all care settings unless stated otherwise. It can transfer across all settings within Gloucestershire and is designed to be recognised nationally.

2. Key Messages

ReSPECT conversations are often found to be positive interactions by patients as they ensure that their views, values, and fears have been appreciated. (1)

All members of the multi-disciplinary team (MDT), as well as patients and those important to them and staff in the voluntary, community and social enterprise sector can contribute to the ReSPECT process.

A ReSPECT conversation can be initiated at any point in a patient's life ideally when a patient is not experiencing an acute episode or expected to die in the near future.

ReSPECT conversations are particularly important to undertake when a patient has significant long-term chronic conditions, or life limiting conditions.

ReSPECT plans are **not a legally binding** document, as all scenarios cannot be predicted. Should a patient feel that something needs to be legally binding an Advance directive to refuse treatment (ADRT) should be considered.

Patients who have a completed ReSPECT conversation and plan may still be considered for all treatments including cardiopulmonary resuscitation (CPR) attempts. For decisions relating to CPR follow guidance relating to CPR decisions. (2)

Communication and good record keeping are central to the safe and effective use of the ReSPECT plan.

The ReSPECT plan does not replace clinical notes and both should be completed

A ReSPECT plan complements additional detailed advance care planning documentations such as an ADRT or health passport. (3)

The original ReSPECT plan should be held by the patient and stored where it is easily found in emergency, ideally in a “what matters to me” orange folder. (4)

The ReSPECT plan should be taken to and reviewed at any clinical encounter, including emergency admission.

The patient should be encouraged to share the information with all appropriate associates and keep a copy of the most up-to-date plan.

ReSPECT plans must be reviewed when a person’s condition or wishes significantly change, or when they are transferred / admitted / discharged from one healthcare provider to another.

An Independent mental capacity advocate (IMCA) may need to be consulted in the event of an individual lacking capacity and if there is no-one who can contribute to a best interests meeting. (5)

3. Introduction

A ReSPECT plan is created through conversations between a patient (or their LPA (Health and Welfare) if they lack capacity to undertake a ReSPECT discussion), (12) the people important to them and health / care professionals to understand what matters to them and what options are available for their care and treatment.

It is important that the healthcare professionals gain the pertinent information about a patient's priorities to enable them to offer information on appropriate treatment options in a way that **suits the individual's needs and requirements.**

Clinicians should be responsive to signals from the individual which may indicate they do not wish to take part in discussions so as not to cause psychological harm to that patient. Even in these circumstances, it is likely that the individual's situation at home, values and fears can be elicited without harm to the patient to guide clinical recommendations. (7)

The existence of a ReSPECT plan does not translate into a particular clinical course, e.g., Having a ReSPECT plan **does not** always mean that an attempt at CPR is not recommended. It is therefore important for all staff to familiarise themselves with the content of any ReSPECT plan for the person they are caring for. (2)

A ReSPECT plan can cover all treatments and care options-for example, antimicrobial therapy, artificial ventilation, artificial nutrition/hydration, preferred location of treatment, spiritual needs, and reasonable adjustments as well as many others. A ReSPECT plan can be discussed and used even in the absence of advanced, or indeed any, illness.

A ReSPECT plan will never be able to cover every possible set of circumstances. However, it can be used to reference a patient's values and fears and then clinical judgement can be used to determine the best course of action.

In the situation of a cardiac arrest, the presumption should be in favour of an attempt at CPR, if there is any doubt and it is clinically indicated. Specific invasive or resuscitative procedures should be recorded if they are likely to be pertinent to the patient e.g. suction of tracheostomy tube or choking in a patient at risk of aspiration with clear guidance of what is and isn't appropriate. (2)

4. ReSPECT conversations

A ReSPECT conversation follows the ReSPECT process by:

- The ReSPECT conversation is ideally suited to be undertaken by multiple individuals over a period of time. Each individual should complete any section they are competent to complete with reference to any previously entered information.
- **Defining the current situation and identifying personal preferences and fears is central to any ReSPECT plan**. Ideally, no clinical recommendation should be made without this vital information (but decisions will be required if

the person does not have capacity and there are no family members to support a discussion).

- Personal preferences should be used to agree a focus of care (extending life, balancing extending life with comfort and valued outcomes or more towards prioritising comfort).
- Making and recording a shared decision about treatments and if an attempt at CPR is recommended. (2)

Clinical uncertainty is greater in patients approaching the end of their life, making a ReSPECT plan even more important at that time. Tools such as the surprise question and Supportive and Palliative Care Indicator Tool (SPICT) can be used by clinicians to identify these patients. (8)
Resources can also be found at the gold standards framework website. (9)

It is useful to include patients preferred place of death and views around admission to hospital in the ReSPECT plan.

5. Completion of the ReSPECT Plan

Any health and care professional contributing to a ReSPECT plan should only act within, and complete the sections appropriate to, their training and competence.
Any professional contributing to the ReSPECT plan should complete their details and sign the plan in section. (7)

A senior clinician should take overall clinical responsibility, and confirm awareness of the plan, by signing in the appropriate box; this will usually be a consultant or general practitioner (GP). (note: this may be delegated to ST3/senior specialty doctor during hospital admission).

It is important that the responsible clinician is made aware of the ReSPECT plan in a timely fashion (photograph or scan of the original may be appropriate to ensure information sharing is timely).

A ReSPECT plan is still valid if some sections are not completed (including the signature of the lead clinician or a CPR recommendation e.g. if only sections 1, 2 and 3 have been completed).

A temporary lead clinician may need to be informed depending on the situation e.g. admitting hospital consultant or out of hours GP.

Record keeping

Copies of the plan should be stored and detailed notes about the conversation should be made in the patient's records.

An electronic signature or name is acceptable.

Each review, update or modification requires a separate entry in the notes and the lead clinician should be updated about significant changes.

Coding and consent to share the document should be completed as applicable.

Please refer to your own professional and local guidelines re coding and documentation standards.

It is appropriate to annotate or add to a ReSPECT plan. if a large alteration is being made the ReSPECT plan should be rewritten.

All sections should only be completed by somebody with the appropriate training, competence, experience, and skill to do so. This is particularly the case with clinical recommendations. The competence of a particular clinician to provide recommendations depends on the clinical picture and circumstances

It is appropriate for clinicians to only add guidance pertaining to their particular expertise, allowing others to address different issues.

If a clinician is unsure as to the appropriate recommendations, it is their responsibility to seek guidance from a senior or specialty clinician, in a timely fashion and document this appropriately. Please refer to your own professional and local guidelines re coding and documentation standards.

A printed or handwritten copy of a ReSPECT plan (regardless of colour or copy) is acceptable unless there is evidence it is invalid.

If the original plan is not with the patient, reasonable steps should be taken to obtain the plan ,review the ReSPECT conversation and if necessary, a new plan should be completed at the earliest opportunity.

6. Clinical Responsibility and Clinical Recommendations

The most senior registered health care professorial currently in charge of the individual's care, at the time the ReSPECT plan is made, carries responsibility for the clinical recommendations until the patient is formally transferred to the care of another consultant or GP.

With regards to making a recommendation regarding an attempt at CPR and other clinical recommendations, these should only be completed by suitably experienced Doctors, Physician Associates, Advanced Clinical Practitioners, Clinical Nurse Specialists, and other categories of Specialist Practitioners having had appropriate training and are competent and confident to do so. Each organisation may need to outline roles and responsibilities given the breadth of staff groups for clarity.

An ADRT is a legally binding document and should be read with a ReSPECT plan if the person has an ADRT. (3)

Clinical recommendations will never cover every clinical scenario. In this situation the patient's fears and values should be used to guide treatment as well as seeking information from other sources. Clinical judgement should be used in every emergency situation.

Lack of agreement

A clinician cannot be forced to give treatment that they consider not to be in the best interests of the individual/patient, including an attempt at CPR.

If there is disagreement, further discussion of the fears and wishes of the patient and whether a particular treatment is likely to provide the desired benefits or outcomes, should occur. There should also be discussion around the risks of any treatment.

A person can request a second opinion if there is disagreement and may benefit from a period of reflection/further meeting.

Clear documentation is essential both in the patient's notes and on the ReSPECT plan.

If agreement over clinical recommendations cannot be reached it is even more essential that sections 1,2 and 3 are completed in detail. Lack of agreement over clinical recommendation should not result in no ReSPECT plan being completed but may result in certain clinical recommendations being omitted

The responsibility for appropriate options, especially in an emergency, rests with the consultant /GP in charge of the patient's care and the usual rules of consent and capacity should be observed. (12,13)

A ReSPECT plan may be changed due to improvement in a patient's condition as well as deterioration. It is good practice to rewrite a new ReSPECT plan rather than annotate, in the case of significant change, to avoid confusion.

7. If the patient with a ReSPECT plan is admitted to hospital:

The most recent/up-to-date ReSPECT plan should be kept in the patient's end of bed notes. This is applicable to acute and community hospital sites.

Duplicate or out of date ReSPECT plans should be filed in the main patient notes. (Two diagonal lines should be drawn across the plan with the word "cancelled", the date and a signature in between the lines.)

The ReSPECT plan should be reviewed on admission for information and discussed with the patient (and/or those close to them) to ensure its validity and that nothing has changed from the patient's point of view. Any review and update should be documented in the patient notes and on the ReSPECT plan (in section 9 of the plan).

A further review MUST be completed on any transfer either within or out of the hospital.

Information about the existence of a ReSPECT plan should be shared with all relevant care professionals through electronic patient records, ward handovers, discharge summary, and patient letters.

If a new ReSPECT plan needs to be initiated during an acute admission, it is recognised that the focus may need to be on inpatient emergency care only. The ReSPECT plan will need to be revisited and adjusted as clinical condition allows and at discharge.

In the event of a patient undergoing general anaesthesia, the ReSPECT plan should be acknowledged, reviewed, and discussed with the patient and clinical team, both in the preoperative setting and immediately prior to the operation and any recommendation not to attempt CPR reviewed with reference to the anaesthetic and perioperative. (10)

On discharge, staff must ensure the ReSPECT plan is copied and added to the notes, documented within the discharge summary and that the patient/LPA (Health and Welfare)/Next of kin (NOK) understands the document and who to share it with.

The original ReSPECT plan should, ideally be placed in a “What matters to me” orange folder and returned to the patient at discharge.

Any transfer or transport team must be made aware of the ReSPECT plan prior to transfer.

8. Do not attempt cardiopulmonary resuscitation (DNACPR) proforma from another region

Any patient attending for care within Gloucestershire with an active DNACPR proforma from another region, should have this decision reviewed at the first opportunity and a ReSPECT plan should be completed either in addition (if the patient is receiving care in multiple areas both within and outside Gloucestershire),or the information should be transferred to a ReSPECT plan (if the patient is transferring their care to Gloucestershire).

Any advance care plan/treatment escalation plan should be assessed for validity and followed if someone is from another area or the plan was written prior to Gloucestershire adopting the ReSPECT plan.

A review of the ReSPECT plan may be very brief but should still occur especially as it may prompt discussions if a patient changes their values and fears during the course of a treatment.

9. Reviewing a ReSPECT plan.

Patient personal circumstances and their conditions change over time, and this will affect their values and fears as well as the appropriateness of certain clinical options. It is therefore essential that the ReSPECT conversation is revisited, and the plan updated regularly but particularly (not exclusively):

- when there is a significant clinical encounter for example outpatient clinics or unscheduled admission to hospital
- Whenever the patient is admitted, discharged, or transferred from one healthcare provider to another-ideally within 48hrs.
- preoperatively,
- Whenever changes occur in the patient's condition
- An increased care requirement (suggesting increased frailty),
- Change in residential setting, e.g. moving to residential care.
- When a new diagnosis is made
- If there is a change in the patient's expressed wishes/at the patient's request.

ReSPECT plans have no 'time limit'/expiration date but should be reviewed with appropriate regularity (frequency will depend on the patient's situation and condition).

Prior to changing a ReSPECT plan, a discussion should take place with the patient/family/LPA (Health and Welfare)/IMCA.

If a ReSPECT plan is re-written or cancelled two diagonal lines should be drawn across the plan with the word "cancelled", with the date and a signature in between the lines. This cancelled plan should be filed at the back of the medical notes and the discussion documented. It is important to update other key healthcare professionals who may hold a copy of a ReSPECT plan.

10. ReSPECT in Care Homes

All care home residents should be offered the opportunity to have a ReSPECT conversation and develop a plan as part of the admission process.

No-one should be coerced into having a ReSPECT conversation and/or plan made if they make an informed choice not to do so.

11. ReSPECT for children and young people

In Gloucestershire, the Children & Young Peoples Advance Care Plan (CYPACP)/ReSPECT document is used, which encompasses the ReSPECT plan.

12. Process for monitoring compliance.

Each organisation will aim to monitor quality and compliance of the ReSPECT process on a regular, locally agreed basis.

Spot-check audits are encouraged. A countywide audit tool is available for this purpose.

All monitoring and audit results must be presented to appropriate bodies , issues addressed and trends recorded and actioned appropriately.

As a nationally produced document, One Gloucestershire are not in control of release of new versions.
The ICB will assess any new versions. If any versions are deemed to no longer fulfil the needs of Gloucestershire this will be decided and appropriate action taken.
All Gloucestershire organisations should strive to use the most up-to-date version of the ReSPECT plan but previous versions remain valid in a clinical situation

13. Training and education

ReSPECT conversations should form part of all clinical training but especially training in chronic conditions, resuscitation, or emergency training

It is the responsibility of each organisation to ensure that all staff including non-clinical staff receive appropriate training.

A link to the tiered ReSPECT training and education framework can be found in the Appendix.

This guidance must be read in accordance with several other acts and guidance. It is particularly important that those using this document understand ADRT, resuscitation and cardiopulmonary resuscitation, LPA (Health and Welfare), IMCA, mental capacity act, documentation, and communication. It is beyond the scope of this document to describe all of these and therefore people are encouraged to consult the references provided.

This policy must be made available to people on request.

References

1. Eli et al (2024) “Patient and relative experiences of the ReSPECT process in the community: an interview-based study”. BMC Primary Care, 25:115 [online]. Available at: Patient and relative experiences of the ReSPECT process in the community: an interview-based study | BMC Primary Care | Full Text

2. Decisions relating to cardiopulmonary resuscitation (2016). Guidance from the British Medical Association, the Resuscitation Council UK, and the Royal College of Nursing [online]. Available at: bma-decisions-relating-to-cpr-2016.pdf

3. NHS (2023) “Advance Decision to refuse treatment (Living Will) [online]. Available at: Advance decision (living will) - NHS

4. Gloucestershire Carers Hub (2022) “What matters to me” [online]. Available at Orange Folder What Matters to me (awaiting update of information from Lisa Carr).

5. Office of the public guardian (2007) “Making decisions – The independent mental capacity advocate (IMCA) service” [online]. Available at Making decisions. The Independent Mental Capacity Advocate (IMCA) service

6. NHS (2024) “Giving someone power of attorney”. [online].Available at: Giving someone power of attorney - Social care and support guide - NHS

7. Resuscitation Council UK (2025) “ReSPECT for healthcare professionals” [online]. Available at: ReSPECT for healthcare professionals | Resuscitation Council UK

8. Supportive and Palliative Care Indicators Tool (2025) [online]. Available at: SPICT – Supportive and Palliative Care Indicators Tool

9. National Gold Standards framework Centre (2025) “The Gold Standards Framework” [online]. Available at: Welcome to Gold Standards Framework

10. Association of Anaesthetists (2025) “Implementing advance care plans in the peri-operative period, including plans for cardiopulmonary resuscitation” [online]. Available at: Implementing advance care plans in the peri-operative period, including plans for cardiopulmonary resuscitation | Association of Anaesthetists

11. NHS England (2025) “Personalised Care” [online]. Available at NHS England » Personalised care

12. UK Government legislation (2025) “Mental Capacity Act 2005” [online]. Available at: Mental Capacity Act 2005

13. NHS England (2025) “Decision making and Consent” [online]. Available at NHS England » Decision making and consent

Additional Reading

Advance Decision to Refuse Treatment, a guide for health and social care professionals. London: Department of Health. Advance-Decisions-to-Refuse-Treatment-Guide.pdf

British Medical Association, (2000). The impact of the Human Rights Act 1998 on medical decision-making. London, BMA Books.

British Medical Association, (2001). Withholding or withdrawing life-prolonging medical treatment. 2nd ed. London, BMA Books.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland 2010.

GMC Treatment and Care Towards the end of life: good practice in decision making 2010.

Human Rights Act. (1998) London: Crown Copyright. www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1.

Tracey v Cambridge University Hospitals NHS Foundation Trust and others [2014] EWCA Civ 33.

Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy NHS South Central 2010.

Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB)

Appendices

1.	Resuscitation Council UK "Specimen ReSPECT Plan – Version 3".	ReSPECT_v3-1_Form_Specimen_FINAL.pdf
2.	Resuscitation Council UK– ReSPECT for Healthcare professionals	ReSPECT for healthcare professionals | Resuscitation Council UK
3.	Resuscitation Council UK – ReSPECT for patients and carers	ReSPECT for patients and carers | Resuscitation Council UK
4.	One Gloucestershire link to ReSPECT training resources	ReSPECT Training Framework : NHS Gloucestershire ICB

Appendix 5

List of roles that are suited to assist in starting the process, and/or having conversations and/or making recommendations on a ReSPECT plan.

Anyone contributing to the ReSPECT process must have completed appropriate training related to their role and should only complete the part of the plan that they are competent and confident to do so.

With regards to making a recommendation regarding CPR and other clinical recommendations, these should only be completed by suitably experienced Doctors, Physician Associates, Advanced Clinical Practitioners, Clinical Nurse Specialists, and other categories of Specialist Practitioners having had appropriate training and are competent and confident to do so.

Each organisation may need to outline roles and responsibilities given the breadth of staff groups for clarity.

Allied Health Professionals
Care home staff
Carers
Charity Support Worker
Consultants
Frailty matrons
GP
Health care assistants (HCA)
Nurses
Paramedics
Resident doctors
Social Prescribers
Social workers
Specialist nurses