

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 plan is a person held document and the **original** document should stay with 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 plan is with the person, **Check** on Summary Care Record if one has been coded.

Plans 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 plan 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 sections 2 and 3 related to the person and what matters to them, their values and fears, with the aim of 'painting a picture' of the person. It is impossible to cover every possibility in the 'clinical recommendations' box but knowing what matters to the person can help a health care professional make a decision in an emergency.
- 3** The clinical recommendations on the plan should be written to support the next care provider/professional to review the plan. 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 using a frailty score/performance status if this is appropriate for the person.
 - 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 overleaf.

What to write on the **ReSPECT** form

Some useful phrases/ways of documenting values and fears and clinical recommendations:

Values and Fears

- 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

Example statements:

- 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 care 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.

Example explanatory summaries:

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.

XXX has a 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.

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.