One Gloucestershire
Transforming Care, Transforming Communities

ReSPECT Form – Section 2

Example summaries of useful and less useful information

Section 2 gives a clear summary of the person's current health and how things may change.
It should help anyone understand the situation quickly. Keep wording simple and avoid unnecessary detail.

Tips for those completing Section 2:

- Use the person's own words where possible, or plain language that the person and family understand.
- Check the person (or those speaking for them) understands and agrees with what is written.
- Keep the language clear and avoid assumptions about the current condition.
- Focus on information that will help decision making in an emergency, e.g. communication needs and how to support them or expected changes in their health if known.
- Avoid copying information directly from clinical records

Useful Examples

Living with advanced heart failure. Has good days and bad days. Gets breathless walking short distances. Symptoms have been gradually worsening over the last year. Walks with a stick.

COPD with frequent winter flare-ups. Uses inhalers but still gets breathless. May deteriorate quickly during infections. Has bed and toilet downstairs for use when needed.

Parkinson's with increasing stiffness and tremors, and moderate dementia. Needs support with dressing and preparing meals. Daughter lives locally and visits daily.
Speaks more slowly when tired. Symptoms are gradually progressing. Speak slowly and offer one instruction at a time.

Increasing frailty. Mobility has reduced and uses a frame indoors. Has had two falls in the past six months. Energy levels vary day-to-day. Feels is now becoming less mobile over time. Significant hearing loss and uses hearing aids.

Person has a moderate learning disability. Understands information best when it is given slowly and in small steps. Needs extra time to process questions and uses pictures to help with explanations. Has epilepsy, well-controlled, but seizures make recovery slower. Changes in routine can increase anxiety.

History of severe depression. Energy and motivation are low, especially on waking.
Finds decision-making difficult when distressed. Risk increases during times of physical illness.
Needs clear, calm explanations and time to ask questions.

English is not their first language. Understands everyday conversation but needs an interpreter for medical information. Has diabetes and struggles with low energy when unwell. Infections tend to set him back for several weeks.

What to Avoid in Section 2
- Long lists of past medical history.
- Medication lists.
- Jargon or abbreviations.
- Vague statements.
- Speculation without clarity.

Less useful examples

Unnecessary Medical detail or copying directly from the GP summary - Too clinical, not focused on current needs

PMH: MI 2008, CABG 2011, COPD, OA, HTN, T2DM…
Takes furosemide, ramipril, apixaban, gabapentin, metformin, Spiriva, beclomethasone and salbutamol

Use of jargon or abbreviations - Not understandable to most people

Active Problems: AF, OA, CKD3a, B12 deficiency, hypothyroidism, recurrent UTIs, post-herpetic neuralgia

Severe LVSD with EF 25%, NYHA Class III.

Exacerbation risk high due to severe COPD GOLD stage IV with chronic hypercapnia

Vague statements - Doesn't help with clinical decision-making

Has lots of health issues and struggles sometimes.

Has learning disability. Doesn't understand things.

Speculation without clarity - Instead, describe what changes are expected, if known.

Probably going to decline soon.