

Guidance for recording on a ReSPECT form

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name: _____
 Date of birth: _____
 Address: _____
 NHS/CHI/Health and care number: _____

1. This plan belongs to:
 Preferred name: _____
 Date completed: _____

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition
 Summary of relevant information for this plan including diagnoses and relevant personal circumstances: _____
 Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer): _____

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 Yes No

3. What matters to me in decisions about my treatment and care in an emergency
 Living as long as possible matters most to me Quality of life and comfort matters most to me
 What I most value: _____ What I most fear / wish to avoid: _____

4. Clinical recommendations for emergency care and treatment
 Prioritise extending life or Balance extending life with comfort and valued outcomes or Prioritise comfort
 clinician signature _____ clinician signature _____ clinician signature _____
 Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance: _____
 CPR attempts recommended Adult or child For modified CPR Child only, as detailed above CPR attempts NOT recommended Adult or child
 clinician signature _____ clinician signature _____ clinician signature _____
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5. Capacity for involvement in making this plan
 Does the person have capacity to participate in making recommendations on this plan? Yes No
 If no, in what way does this person lack capacity? _____
 Document the full capacity assessment in the clinical record. _____
 If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan
 The clinician(s) signing this plan is/are confirming that (select A, B or C, OR complete section D below):
 A This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
 B This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
 C This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
 1 They have sufficient maturity and understanding to participate in making this plan
 2 They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
 3 Those holding parental responsibility have been fully involved in discussing and making this plan.
 D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time

 Senior responsible clinician: _____

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: <input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

 If this page is on a separate sheet from the first page: Name: _____ DoB: _____ ID number: _____
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Section 1- Patient demographics. Write legibly

Section 2
 Summary of a shared understanding of the patient's relevant medical history, current condition and how these might progress or change. **Avoid medical jargon or abbreviations.** Record relevant details and location of any Advance Decision to Refuse Treatment forms or Advance Care Plans.

Section 3 'What matters to me'
 Base this on a shared understanding as above. Ask the person to consider the goals of care and treatment and describe their priorities. Use the scale to help them understand the balance between a focus on comfort versus sustaining life. Explain that this plan is for use only when they cannot make decisions about emergency care and treatment.

Section 4
 Record clear recommendations about the care and treatment that;

- Would be wanted to achieve goals of care
- Would not be wanted
- Would not work in this person's situation
- Your reasoning for these recommendations

Discuss, agree and record recommendation about CPR. **Be clear and succinct**

Section 5
 Record whether the person has mental capacity or not.

Section 6
 To confirm that the process and form have been completed lawfully in accordance with mental capacity act and human rights law, document who was involved in discussing and agreeing the recommendations recorded. Record the dates of the ReSPECT conversation and the names and roles of those involved. **Sign and date the form**

Section 9
 This section should be left blank at the time of the initial completion of the form. The form should be reviewed when the patient moves from one healthcare setting to another, if the patient's circumstances, wishes or preferences have changed. There is not a defined expiry date as the need for review must be considered carefully according to the individual's needs.

The ReSPECT form is a summary document – more detailed records must be made in the patient's medical and nursing record. Any ReSPECT forms that are no longer valid should be clearly marked cancelled with two diagonal lines, legible signature (name and registration number) and dated.