Resuscitation Council UK

ReSPECT

The ReSPECT process - A guide for clinicians completing the form

Before you start:

- Remember that completing the form is only part of the ReSPECT process.
- You can use the sequence of sections on the form to guide you through the conversation that is an essential part of that process.
- Do **not** complete the form without maximum possible involvement of the person in the process (or of those best able to speak for them if they do not have capacity for involvement).
- Use the form to summarise what was discussed and agreed. Document more detailed information in the person's health record.

Section 1: "This plan belongs to"

Complete all details fully and clearly. Those responding to a future emergency must be able to identify the person immediately and confidently.

Section 2: "Shared understanding of my health and current condition"

Discuss, explain and achieve a shared understanding of the person's relevant health conditions and how these may progress or change. Summarise in this section's three boxes:

- Relevant conditions and circumstances. Do not record unnecessary detail (e.g. of past medical history, medication). Include communication problems and how to overcome them. Make sure that the person (or anyone speaking for them) knows and agrees with what you record.
- Specific detail of any other planning documents and where to find them.
- Whether or not they have a legal proxy. If so, put name and contact details in section 8.

Section 3: "What matters to me in decisions about my treatment and care in an emergency"

- Summarise what the person says would matter most to them (values and fears), both in daily life and as an outcome of future emergency treatment. If possible, use their own words. If the person does not have capacity to participate, whenever possible family or other representatives must be involved in establishing the person's likely wishes.
- Use the scale in section 3 to help the person understand how some people want all possible interventions to try to live as long as possible, others want care to focus only on maintaining their comfort and many want a balance between these. If they want to, the person can mark the scale to show their current wish; do not pressurise them to do this.
- Explain that this plan is for use only when they cannot make decisions about emergency care and treatment. If they can make decisions, they can make choices at the time.

Section 4: "Clinical recommendations for emergency care and treatment"

Record recommendations for a future emergency on interventions that:

- could result in desired outcomes and would be wanted
- are likely to result in a feared outcome and would not be wanted
- have little or no realistic chance of success, so would not work.

Following from clinical understanding and the values and fears agreed in sections 2 and 3, establish an agreed overall goal of care, and sign one of the three boxes:

- **Prioritise extending life:** They would receive treatment to control symptoms, and would want potentially life-sustaining treatments, even if they involve some discomfort and/or risk.
- **Balance extending life with comfort and valued outcomes:** They would want some potentially life-sustaining treatments in some circumstances.
- **Prioritise comfort:** They want care and treatment to control symptoms and maintain their comfort. This does not mean that they should not receive (for example) an antibiotic for an infection. They would not want invasive intervention with a primary purpose of extending life.

Next, record freehand clinical recommendations on **specific interventions** that would or would not be wanted or clinically appropriate, and summarise the reason for these. This may include whether the person would want to be taken to hospital and in what circumstances. Include other relevant recommendations (e.g. whether they should be considered for intensive care, or for 'invasive' ventilation). Complete this box clearly. Avoid jargon; use wording that will be easily understood by all who may respond to an emergency in any health or care setting.

Now, after discussion and agreement, sign in **ONE** of the boxes to indicate whether CPR attempts are recommended (or, in a child, whether a plan for modified CPR has been agreed).
A recommendation about CPR should be discussed within the discussion of overall goals of care, along with an honest explanation of what treatments can realistically be expected to achieve those goals. Remember that clinicians **must** discuss a recommendation not to attempt CPR with the person concerned, unless it is thought that it will cause physiological or psychological harm; if you believe this is so, you must document your reasons in section 6 and in the person's health record.

Section 5: "Capacity for involvement in making this plan"

- Assume the person has capacity.
- If you suspect the person has an impairment or disturbance of mind or brain, you must test their capacity for each specific decision. If the person lacks capacity for a specific decision, or they cannot have capacity (e.g. they are unconscious), the decision must be made by following the requirements of capacity legislation.

Section 6: "Involvement in making this plan"

Select **A, B** or **C** as appropriate, or complete section **D**. Select **D** – if there has been:

- no involvement of the person (adult with capacity or child with sufficient maturity and understanding) because you believe it would cause physiological or psychological harm
- no involvement of family or other representatives of a person who lacks capacity, because you believe this impracticable or inappropriate (e.g. no contact details or you believe that contacting a frail family member in the middle of the night would place them at risk)
- no involvement of those with parental responsibility for a child.

Summarise your reasons here; document them fully in the clinical record, together with a clearly defined plan to involve the person and/or their representatives as soon as possible/appropriate.

Section 7: "Clinicians' signatures"

As the professional who completed the ReSPECT form, you must sign this section and record the date and time. If you are not the senior responsible clinician, inform them of the plan and – at the earliest practicable time – they should review and endorse it by signing the shaded line (or – if appropriate – undertake further discussion and revision of the plan before signing it).

Section 8: "Emergency contacts and those involved in discussing this plan"

- If they want to, let the person and/or those close to them confirm their involvement by signing here.
- Their signatures are optional. They do not make the plan any more or less valid, or legally binding.
- Record details of people to be contacted in an emergency. Remember that the form is for use across all health and care settings.

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

- Leave this blank at initial plan completion.
- Review may be prompted by a request from the person or their representative, by a change in their condition or by their transfer from one care setting to another. The responsible clinician should review the ReSPECT form entries, and discuss the plan with the person themselves, unless to do so is justifiably unnecessary or would be harmful to them. If the recommendations are still appropriate, they should sign and date Section 9 to confirm this.
- If the recommendations are (or may be) no longer correct, they should be discussed and reviewed with the person (or representative(s) of a person who lacks capacity) and – where appropriate – a new ReSPECT form should be completed.