

1. Personal details

Insert clearly the person's full name, date of birth and address. Insert the date on which the form is completed. Whenever possible, include their NHS/ CHI health and care number.

Preferred name

Ask the person (or if they cannot answer ask their family or other carers) the name by which they would like to be addressed.

2. Summary of relevant information for this plan

Whenever possible complete this in discussion with the person and with reference to available health records. If they do not have capacity to participate in decisions, whenever possible complete this in discussion with their family or other representatives.

- A. Insert a brief summary of the background to the recommendations in section 4 (e.g. diagnosis, previous and present condition, prognosis, communication difficulties and how to overcome them);
- B. Record specific detail and the location of documents such as advance statements, Advance Decisions to Refuse Treatment, advance care plans, organ donor cards.

3. Personal preferences to guide this plan (when the person has capacity)

Ask the person to describe their priorities for their care. The scale can be used to help them to understand how, for some, the emphasis may change from focusing on all possible interventions to try to sustain life to focusing primarily or mainly on care and treatment to control symptoms. The scale can be used to aid discussion only, or a mark can be made on it if they wish. Remember to explain that this plan is for use in an emergency when the person is not able to make decisions about their care and treatment. If they are able to make decisions, they can make choices at the time.

Prioritise sustaining life... Prioritising life-sustaining treatments does not mean that the person would not receive treatment to control symptoms, but they may want to be considered for some life-sustaining treatments that involve a degree of discomfort. There may be clear limits to the types of care and treatment the person would or would not want to be considered for, and on the circumstances in which they would or would not want those.

Prioritise comfort... Prioritising comfort indicates that the person wants primarily those types of care and treatment whose purpose is to control symptoms and provide comfort. This does not mean that the person would not be offered (for example) antibiotic treatment for an infection, especially as that treatment may relieve the symptoms caused by the infection. However the person would not want more invasive types of treatment that involve some discomfort and some risk and whose primary purpose is to sustain life rather than relieve discomfort. The second box is to allow individuals to have recorded the aspect of their life that is most important to them. For some this may be maintaining cognitive function, for others maintaining independence or mobility. Some may want all treatments for some time, but would not want to be on life support for a prolonged period.

4. Clinical recommendations for emergency care and treatment

These are the recommendations to guide decision-making in a future emergency. If the person does not have capacity to participate in deciding these recommendations, their family or other representatives should be involved in discussions whenever possible. Start by signing the goal of care as **either** focusing on life-sustaining treatment **or** focusing on symptom control.

Clinical guidance... Record clear detail of those types of care or treatment that the person would or would not want to be considered for and that would or would not work in their individual situation. Include whether or not the person would want to be taken to hospital and in what circumstances. Include other level-of-care decisions, for example whether they should be considered for intensive care admission, or whether (for example) only non-invasive ventilation would be recommended. It is important to complete this box clearly as it is these recommendations that will be used to guide decision-making in an emergency. Remember that the ReSPECT form is not a substitute for recording a detailed clinical assessment and plan of treatment in the person's health record.

CPR decision... Sign ONE of these boxes ONLY. Remember that there must be a presumption in favour of involvement of the person (and/or their family or other representatives) in the decision-making process unless that would cause the person harm. If CPR would not work and is not being offered, that should be explained in the context of the person's priorities and goals of care.

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan?

Consider and answer this question for all adults. If there is any reason to suspect impaired capacity perform a formal assessment of capacity and document it fully in the person's health records.

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations?

Consider and answer this question for adults and children. When the answer is 'yes' insert details in section 8.

6. Involvement in making this plan

The clinician signing this plan...

You must circle at least one of the statements A, B, C, D. Then record the date (or dates) of conversations about the recommendations and the names and roles of those involved. Make sure that detail of what was discussed and agreed is documented in the health record. On the ReSPECT form record where that further detail has been documented.

If this plan is being completed without involving the patient...

If there has been no shared decision-making with the person themselves (or no involvement of family or other representatives of a person who does not have capacity to be involved) use the red-bordered box to summarise the reasons for this. Make sure that the reasons are detailed fully in the clinical record, together with a clearly defined plan to involve the person or their representatives as soon as this is possible or appropriate.

7. Clinicians' signatures

Clinicians' signatures...

This section **must** be signed (inserting also the date and time of signing) by the professional who completes the ReSPECT form. If that is not the senior responsible clinician, they should be informed of the plan's completion, and at the earliest practicable opportunity they should review and endorse the recommendations by adding their signature (or, if appropriate, consider further discussion and possible revision of the plan). The senior responsible clinician will usually be the person's GP or consultant. In some situations (e.g. nurse-led units) a senior nurse may have this role.

8. Emergency contacts

Use this section to record contact details of people who should be considered for immediate contact in the event of major deterioration, imminent death, or any change in the person's condition that may warrant reconsideration of the previously recorded recommendations.

9. Confirmation of validity (e.g. for change of condition)

This section should be left blank at the time of initial completion of the plan. Remember to document in the health records whether and when review of the recommendations on this ReSPECT form should be considered. The recommendations on the ReSPECT form do not have a defined expiry date, as the need for review must be considered carefully for each person at each stage of their clinical progress. Review may be prompted by a request from the person or their representative, by a change in the person's condition or by their transfer from one care setting to another. In any of these situations, it is good practice for the responsible clinician to review the content of the ReSPECT form. If they confirm that the recommendations are still correct and appropriate, they should sign and date the review box to indicate that review has occurred. If the recommendations may no longer be correct, another conversation should be had with the patient and, where appropriate, a new ReSPECT form created.