One Gloucestershire
Transforming Care, Transforming Communities

ReSPECT

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 follow 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 EPR systems if one has been coded.

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.

There could be many clinicians involved in the ReSPECT process, **Ask** to see the plan, **Check** for a signature from one of the clinicians 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 upon change of care setting.

2. Write plenty of details in the 'what matters to me' box (Section 3). It is impossible to cover every possibility in the 'recommendations' box but knowing what matters to the person can help a health care professional make a decision in an emergency.

3. The guidance 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 frailty score/performance status but not appropriate for chronic physical or learning disability/autism.
   - 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.

Please see examples overleaf.

Adapted from: Countywide ACP/ReSPECT Steering Group Glos EOLC CPG

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What to write on the ReSPECT plan

Some useful phrases/ways of documenting priorities and recommendations:

What matters to the patient

- 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.

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. Would consider hospital admission if there is a reversible cause for any deterioration in condition which cannot be managed in the community. Ceiling of hospital care is ward based care.

Less useful phrases:

- Ward based care (especially when present on a plan 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.