

How to check if the **R^oSPECT** form has been filled in correctly

Section 1: Personal details

Clearly showing the...

Person's full name, date of birth and address.

Date on which the form was completed.

NHS or CHI number (unless they do not have one).

Name the person would like to be addressed by, in some instances.

Section 2: Summary of relevant information for this plan

Summary of the person's background which relate to the recommendations made in the following sections of the form.

Relevant diagnoses, present state of health, expected prognosis, communication difficulties and how to overcome them can be included.

There may be a record of further documents such as Advance Decisions to Refuse Treatment, advance care plans, advance statements, or organ donor cards, and where to find them.

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

Record of the person's agreed priorities of care - be it prioritising sustaining life or prioritising comfort.

Record of the things most important to them in their life.

In some instances, there may be a mark on the scale to indicate the person's current priorities for care.

Section 4: Clinical recommendations for emergency care and treatment

Record of recommendations to guide immediate decision-making in a future emergency based on the priorities of care.

Only one of the boxes should be signed to indicate if the focus is on life-sustaining treatment or focus on symptom control. Specific recommendations should be recorded below.

Record of whether or not attempted CPR is recommended, and for children only, to recommend modified CPR. Only one of these boxes should be signed. If more than one box is signed then this is a serious error and the senior responsibly clinician needs to be alerted as soon as possible. If an error is noticed in an emergency situation, where the person cannot express their wishes, you must act in their best interests.

Section 5: Capacity and representation at time of completion

Record of whether or not...

The person had capacity to participate in making the recommendations in their plan.

The person has a legal proxy who must be consulted if they lack or lose capacity.

Section 6: Involvement in making this plan

Confirmation that the process and form have been completed lawfully in accordance with capacity and human rights laws, and to document who was involved in discussing and agreeing the recommendations recorded. At least one of the statements A, B, C, D (more than one may apply) should be marked.

If D is circled, indicating 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) the red-bordered box must provide reasons for this. These reasons should be detailed fully in the person's health record.

Record of the date(s) of the ReSPECT conversations, the names and roles of those involved, and where the full details of the discussions can be found in the health record.

Section 7 Clinicians' signatures

Validation of the entries on the form and endorsement by the senior responsible clinician.

The professional who completes the ReSPECT form must add a legible signature and legible name and registration number, and the date and time. If they are not the senior responsible clinician (i.e. GP, consultant or a senior nurse), then the senior responsible clinician should be informed and agree to the plan's completion. The senior responsible clinician should review and endorse the recommendations by adding their signature at the earliest possible opportunity. In some circumstances, they may consider further discussion and possible revision of the plan. Refer to local policy for the timeframe in which the form needs to be countersigned by the senior responsible clinician to remain valid.

Section 8 Emergency contacts

Record of the contact details of key people to 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.

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

For future use to record when the form has been reviewed and the recommendations confirmed to be still valid. This section may be left blank at the time of initial completion of the plan.

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.

Storing the form

Once a form is completed, it is important that the person keeps it with them, and that it is readily available for professionals who may need to see and use it.

At home the ReSPECT form should be kept somewhere accessible, so that their family or other representatives know exactly where to find the ReSPECT form if an emergency occurs. In a hospital, care home, hospice or other organisation the form must be stored in a clearly defined and rapidly accessible place, whether it is in paper or electronic format.