ReSPECT Participant Initials | | | | Participant Study ID | | | | | |

# ReSPECT Evaluation WP3 Case Report Form

## Section 1: Demographics

**1. Gender** Male ☐ Female ☐ Not recorded ☐

**2. Age** | | | | Years

**3. Ethnicity**

| | Cross ONE |
|---|---|
| British / Irish / Any other white background | ☐ |
| Mixed / multiple ethnic groups | ☐ |
| Indian / Pakistani / Bangladeshi / Any other Asian background | ☐ |
| Caribbean / African / Any other Black background | ☐ |
| Chinese / Other ethnic group | ☐ |

**4. Abbreviated home postcode** | | | | |

## Section 2: Details of current hospital admission

**1. Date of admission** D D M M M Y Y

**2. Patient admission category**

| | Cross ONE |
|---|---|
| Transferred from another hospital | ☐ |
| Planned admission | ☐ |
| Referral from GP | ☐ |
| Emergency admission via GP | ☐ |
| Emergency admission via the emergency department | ☐ |
| Other (please specify): | ☐ |

**3. Type of patient**

| | | Cross ONE |
|---|---|---|
| **Medical** | Emergency | ☐ |
| | Elective | ☐ |
| **Surgery** | Emergency | ☐ |
| | Elective | ☐ |

**4. Primary reason for admission**

| Reason | Cross ONE |
|---|---|
| Cancer / neoplasm | ☐ |
| Fall / injury / musculoskeletal | ☐ |
| Gastrointestinal conditions | ☐ |
| Respiratory conditions | ☐ |
| Cardiac conditions | ☐ |
| ENT conditions | ☐ |
| Urological conditions | ☐ |
| Central nervous system conditions | ☐ |
| Infectious disease | ☐ |
| Poisoning | ☐ |
| Gynaecological / obstetric conditions | ☐ |
| Mental health conditions | ☐ |
| Other (please specify): | ☐ |

**5. Does the patient suffer from cognitive impairment?** No ☐ Yes ☐

If yes, complete table below.

| | No | Yes |
|---|---|---|
| Dementia | ☐ | ☐ |
| Learning difficulty | ☐ | ☐ |
| CVA / Head injury | ☐ | ☐ |
| Acute confusional state | ☐ | ☐ |
| Cause unknown | ☐ | ☐ |
| Other (please specify): | | |

## Section 3: Patient status and co-morbidities

### 1. GO-FAR score

| | No | Yes |
|---|---|---|
| 1. Neurologically intact or with minimal deficits at admission | ☐ | ☐ |
| 2. Major trauma | ☐ | ☐ |
| 3. Acute stroke | ☐ | ☐ |
| 4. Metastatic or hematologic cancer | ☐ | ☐ |
| 5. Septicemia | ☐ | ☐ |
| 6. Medical noncardiac diagnosis | ☐ | ☐ |
| 7. Hepatic insufficiency | ☐ | ☐ |
| 8. Admit from skilled nursing facility | ☐ | ☐ |
| 9. Hypotension or hypoperfusion | ☐ | ☐ |
| 10. Renal insufficiency or dialysis | ☐ | ☐ |
| 11. Respiratory insufficiency | ☐ | ☐ |
| 12. Pneumonia | ☐ | ☐ |

### 2. Charlson Comorbidity Index

| Condition | No | Yes |
|---|---|---|
| 1. Myocardial Infarction | ☐ | ☐ |
| 2. Congestive Heart Failure | ☐ | ☐ |
| 3. Peripheral vascular disease | ☐ | ☐ |
| 4. Cerebrovascular disease or transient ischemic disease (CVA) | ☐ | ☐ |
| 5. Hemiplegia | ☐ | ☐ |
| 6. Chronic pulmonary disease | ☐ | ☐ |
| 7. Connective tissue disease | ☐ | ☐ |
| 8. Ulcer disease | ☐ | ☐ |
| 9. Mild liver disease | ☐ | ☐ |
| 10. Moderate or severe liver disease | ☐ | ☐ |
| 11. Diabetes | ☐ | ☐ |
| 12. Diabetes with end-organ damage | ☐ | ☐ |
| 13. Moderate or severe renal disease | ☐ | ☐ |
| 14. Cancer | ☐ | ☐ |
| 15. Metastatic solid tumor | ☐ | ☐ |
| 16. Dementia | ☐ | ☐ |
| 17. AIDS | ☐ | ☐ |
| 18. Hypertension | ☐ | ☐ |
| 19. Skin Ulcer | ☐ | ☐ |
| 20. Depression | ☐ | ☐ |
| 21. Warfarin / NOACs | ☐ | ☐ |

**3. McCabe Scale**

**How would you classify the condition or underlying disease of the patient?**

| | Cross ONE |
|---|---|
| Non-fatal | ☐ |
| Ultimately fatal | ☐ |
| Rapidly fatal | ☐ |

Sections 1-3 completed by

Name _____ Signature _____ Date _____

## Section 4: ReSPECT Form

**1. ReSPECT form present in patient's case notes** No ☐ Yes ☐

*If no, please sign and date this section and continue on to section 5.*

**2. Type of ReSPECT form used at hospital site**

| | Cross ONE |
|---|---|
| Paper version of ReSPECT form used | ☐ |
| Electronic version of ReSPECT form used | ☐ |

**3. Date ReSPECT form completed** D D M M M Y Y Date not recorded ☐

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

Scale completed? No ☐ Yes ☐

*If yes selected,*

Measurements obtainable No ☐ Yes ☐

*If no,*

Measurements unobtainable but prioritise sustaining life preference is recorded ☐

Measurements unobtainable but prioritise comfort preference is recorded ☐

*If yes,*

Measurement 1: mm | | | |

Measurement 2: mm | | | |

**5. Has the clinician completed 'considering the above priorities, what is most important to you is (optional)' box?** No ☐ Yes ☐

**6a. Clinical recommendations for emergency care and treatment**

| | No | Yes | Not recorded |
|---|---|---|---|
| **Focus on life-sustaining treatment** | ☐ | ☐ | ☐ |
| **Focus on symptom control** | ☐ | ☐ | ☐ |
| Unclear position | ☐ | ☐ | |
| Missing | ☐ | ☐ | |

**6b. Clinical guidance on specific interventions**

| | No | Yes | Not recorded |
|---|---|---|---|
| 1. Referral to Intensive Care Unit | ☐ | ☐ | ☐ |
| 2. Referral to High Dependency Unit | ☐ | ☐ | ☐ |
| 3. For full escalation | ☐ | ☐ | ☐ |
| 4. Ward based care only | ☐ | ☐ | ☐ |
| 5. Invasive ventilation | ☐ | ☐ | ☐ |
| 6. Non-invasive ventilation | ☐ | ☐ | ☐ |
| 7. Inotropic support / vasoactive drugs | ☐ | ☐ | ☐ |
| 8. Renal replacement therapy | ☐ | ☐ | ☐ |
| 9. Antibiotics | ☐ | ☐ | ☐ |
| 10. NG / NJ / PEJ / PN feeding | ☐ | ☐ | ☐ |
| 11. Observations / Modified Early Warning Score (MEWS) | ☐ | ☐ | ☐ |
| 12. Clinical hydration | ☐ | ☐ | ☐ |
| 13. Cardioversion | ☐ | ☐ | ☐ |
| 14. Palliative or comfort care | ☐ | ☐ | ☐ |
| 15. Not for hospital readmission | ☐ | ☐ | ☐ |
| 16. Other (please specify): | | | |

**6c. CPR status**

| | Cross ONE |
|---|---|
| **CPR attempts recommended** | ☐ |
| **CPR attempts NOT recommended** | ☐ |
| **Not completed** | ☐ |

**7. Does the person have sufficient capacity?** No ☐ Yes ☐ Not recorded ☐

**8. Do they have a legal proxy?** No ☐ Yes ☐ Unknown ☐ Not recorded ☐

**9a. ReSPECT Form version** Version 1.0 ☐ Version 2.0 ☐

*If Version 1.0 is selected please answer question **9b**. If Version 2.0 is selected please answer question **9c**.*

**ReSPECT FORM VERSION 1.0**

**9b. Involvement in making this plan**

| | No | Yes |
|---|---|---|
| A | ☐ | ☐ |
| B | ☐ | ☐ |
| C | ☐ | ☐ |
| D | ☐ | ☐ |

**If yes selected for D, please cross option why**

Emergency situation ☐ Relative/personal consultee not available ☐

Other ☐ _____

**ReSPECT FORM VERSION 2.0**

**9c. Involvement in making this plan**

| | No | Yes |
|---|---|---|
| A | ☐ | ☐ |
| B | ☐ | ☐ |
| C | ☐ | ☐ |
| D | ☐ | ☐ |

**If C selected, please cross which number(s) are recorded. If C not selected, please leave blank.**

| | No | Yes |
|---|---|---|
| 1 | ☐ | ☐ |
| 2 | ☐ | ☐ |
| 3 | ☐ | ☐ |

**If D selected, please cross option why**

Emergency situation ☐ Relative/personal consultee not available ☐

Other ☐ _____

**10. What is the designation (grade / speciality) of the first clinician who has signed the form?**

| | Cross ONE |
|---|---|
| **FY1** – Foundation Year one Junior Doctor | ☐ |
| **FY2** – Foundation Year two Junior Doctor | ☐ |
| **ST 1-2** – Speciality Trainee in a hospital speciality | ☐ |
| **SpR or ST ≥ 3** – Speciality Registrar / Trainee in a hospital speciality | ☐ |
| **GPST** – Speciality Registrar in general practice | ☐ |
| **Consultant** – in acute hospital or community setting | ☐ |
| **GP** – General Practitioner | ☐ |
| **Nurse / allied health practitioner** | ☐ |
| **Not recorded** | ☐ |

**11. First clinician signature signed?** No ☐ Yes ☐

*If yes,* **Date of first clinician signature** D D M M M Y Y **Date missing** ☐

**12. Signed by senior clinician responsible for patient's care** No ☐ Yes ☐

*If yes,* **Date of senior clinician signature** D D M M M Y Y **Date missing** ☐

Section 4 completed by

Name _____ Signature _____ Date _____

## Section 5: NHS Safety Thermometer

### Classic Safety Thermometer data

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Pressure ulcer | | | | | | | | |
| Old Pressure Ulcers | None ☐ | Grade 2 ☐ | Grade 3 ☐ | Grade 4 ☐ | Ungradeable ☐ | | | Not recorded ☐ |
| New Pressure Ulcers | None ☐ | Grade 2 ☐ | Grade 3 ☐ | Grade 4 ☐ | Ungradeable ☐ | | | Not recorded ☐ |
| Falls | | | | | | | | |
| Falls (and harm) | No fall ☐ | No harm ☐ | Low ☐ | Moderate ☐ | Severe ☐ | Death ☐ | | Not recorded ☐ |
| Urinary tract infection/ urinary catheter | | | | | | | | |
| UTIs | No UTI ☐ | Old UTI ☐ | New UTI ☐ | | | | | Not recorded ☐ |
| Urinary catheter in-situ | No cath. ☐ | 1-28 days ☐ | >28 days ☐ | Days unknown ☐ | | | | Not recorded ☐ |
| Venous thromboembolism (VTE) | | | | | | | | |
| VTE Risk Assessment completed | No ☐ | Yes ☐ | N/A ☐ | | | | | Not recorded ☐ |
| VTE Prophylaxis | No ☐ | Yes ☐ | N/A ☐ | | | | | Not recorded ☐ |
| VTE Treated | None ☐ | Old DVT ☐ | Old PE ☐ | Old Other ☐ | New DVT ☐ | New PE ☐ | New other ☐ | Not recorded ☐ |

Section 5 completed by

_____ _____ _____

Name Signature Date

## Section 6: Details of discharge

**1. Survival to discharge** No ☐ Yes ☐

**2. Date of discharge** D D M M M Y Y Not applicable (patient deceased) ☐

Not applicable (patient not discharged at end of data collection) ☐

**3. Length of hospital stay** | | | | days

**4. Participant's Discharge location**

| | **Cross ONE** |
|---|---|
| Not applicable | ☐ |
| Home | ☐ |
| Inpatient rehabilitation unit | ☐ |
| Nursing / Residential Home | ☐ |
| Another hospital | ☐ |
| Hospice | ☐ |
| Other (please specify): | ☐ |

Section 6 completed by

Name _____ Signature _____ Date _____