ReSPECT **Recommended Summary Plan for Emergency Care and Treatment for:**

Preferred name

## 1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

## 2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

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

How would you balance the priorities for your care (you may mark along the scale, if you wish):

**Prioritise sustaining life,** even at the expense of some comfort

**Prioritise comfort,** even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

## 4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended
Adult or child
clinician signature

For modified CPR
**Child only, as detailed above**
clinician signature

CPR attempts **NOT** recommended
Adult or child
clinician signature

## 5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

## 6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.

☐ **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

**D** If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

## 7. Clinicians' signatures

| Designation (grade/speciality) | Clinician name | GMC/NMC/ HCPC Number | Signature | Date & time |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Senior responsible clinician

## 8. Emergency contacts

| Role | Name | Telephone | Other details |
|---|---|---|---|
| Legal proxy/parent | | | |
| Family/friend/other | | | |
| GP | | | |
| Lead Consultant | | | |

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

| Review date | Designation (grade/speciality) | Clinician name | GMC/NMC/ HCPC number | Signature |
|---|---|---|---|---|
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