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 these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, 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			
GP			
Lead Consultant			
Other			

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

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