ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name	Jane Jones
Date of birth	01/01/1950
Address	My House, Manchester
NHS/CHI/Health and care number	000000000000

1. This plan belongs to:

Preferred name	Jane
Date completed	31/05/2023

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Advanced Heart Failure, diagnosed 5 years ago. MI 3 years ago, CABG, T2 Diabetic on Insulin, Chronic Kidney Disease, stage 3.
Currently retired due to ill health, living with husband in a ground floor flat. Able to mobilise 10 yards unaided.

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

Husband has LPA for Health and Welfare

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ **Yes** ☒ **No**

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me	**Quality of life and comfort matters most to me**
What I most value: Good symptom control, time with family. To be at home at the end of life.	What I most fear / wish to avoid: Unnecessary hospital admissions. Being very breathless

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
clinician signature		clinician signature		clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

Mrs Jones has had a good response to short term IV diuretics for exacerbation of heart failure and would consider again if clinically indicated.
If dependant on continuous IV diuretics, Mrs Jones would wish to prioritise her comfort and being at home.

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature Dr Smith

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Document the full capacity assessment in the clinical record.

- [X] **Yes**
- [ ] **No**

If no, in what way does this person lack capacity?

If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

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):

- [X] **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
- [ ] **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
- [ ] **C** This person is less than 18 years old (16 in Scotland) 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.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Consultant Cardiologist	Dr Smith,	999999999	Dr Smith	31/05/2023
ED, ACP	Sarah Ball	11111111111	S Ball	31/05/2023
Senior responsible clinician: Consultant Cardiology	Dr Smith	99999999999	Dr Smith	

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
John Jones ☒	Husband	0000000000000	optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**