ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name	Winifred Mouse
Date of birth	6.6.31
Address	30 Little Hollow Big Wood SY5 3BD
NHS/CHI/Health and care number	7 7 6 6 5 5 4 4 3 3 2 2

1. This plan belongs to:

Preferred name	Winnie
Date completed	23.8.23

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:

Metastatic renal cell cancer
Heart failure, chronic kidney disease (CKD 4)
Frailty

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):

Full plan recorded on Systmone EPaCCs

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:	What I most fear / wish to avoid:
Being comfortable and pain free	I would like to be at home and do not want to go into hospital, if possible. I would consider Hospice care.

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	Balance extending life with comfort and valued outcomes	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: To deactivate ICD – completed 1.9.23.
To maximise symptom control at home to try to avoid hospital admission. Winnie would consider hospice admission, but please speak to her daughter first
Pre-emptive medication is available in the house.
Winnie is known to District Nursing serivces and the specialist palliative care team (Contact via SPA 01226 644575) or out of hours speak to the hospice palliative on 01226 244244

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

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.	☑ 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):

☑ **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
CNS	Pat Shrew.	9361	P Shrew.	23.9.23
Senior responsible clinician: GP	Dr Rob Fox	932	RFox	23.9.23 15.00

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
Jane Rabbitt RGN ☑	District Nurse	3245	J Rabbitt
Winnie Mouse. ☐	Patient.	2432	optional
June Mouse ☐	Daughter	2596	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:**