ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name	James Brown
Date of birth	3.9.74
Address	1 Cobbled Street, Darkside, S12 4AN
NHS/CHI/Health and care number	7 7 6 6 4 4 3 3 2 2 1 1

1. This plan belongs to:

Preferred name: Jim

Date completed: 25.8.23

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:

Motor Neurone Disease, uses NIV, unable to take oral diet has PEG feeds.
Receives all care in bed but is able to go out in his wheelchair. Uses assisted technology to communicate.

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 EPaCCS, completed on systmone. Jim has a printed version

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 wife Judy ☑ **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 with my family particularly my wife and daughter.	I am fearful of pain and worsening respiratory distress.

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 RBond		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:

Jim understands his condition and that he is at risk of acute deterioration. If treatment would help to manage symptoms or reverse the deterioration he would be happy to transfered to hospital for this. However, if this is unlikely to be successful he would like to die at home, or the hospice. His wife Judy is fully aware of Jim's wishes

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 PBond

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.	If no, in what way does this person lack capacity?
✓ Yes No	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
MND Specialist Nurse	Ivor Jones	5436		25.09.23
Senior responsible clinician: GP	Peter Bond	222	PBond	25.09.23 10am

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: Judy Brown ✓	Parent's wife	2969	optional JBrown
James Brown ✓	Parent	3912	JBrown
Judy Brown ✓	Parent's wife	2969	JBrown
☐			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:**