

Full name	Katherine Parr
Date of birth	20.5.2002
Address	10 Bridge Street Riverside TL6 4BO
NHS/CHI/Health and care number	5 5 4 4 3 3 2 2 1 1 0 0

1. This plan belongs to:

Preferred name	Katie
Date completed	10.8.32

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:
Katie has a history of cerebral palsy and hydrocephalus. She has respiratory difficulties and has a trachyostomy with supplementary oxygen. She is completely dependent for care and uses a wheel chair. She has gastrostomy tube for feeds.

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):
All about me passport

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: Being at home with my family and doing my favourite activities	What I most fear / wish to avoid: Being moved out of my home and it being noisy and busy around me. I like calm.

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	Balance extending life with comfort and valued outcomes	Prioritise comfort
<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>

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: Katie is currently stable + shows pleasure and happiness (smiles and laughter) when she is with her family. Initiation of life sustaining treatment should be made considering her baseline at the time of an acute event/deterioration. Such decisions should be made considering the benefit/burden risk balance and WITH FULL INVOLVEMENT OF HER FAMILY (Parents). This may change in the future if her general condition deteriorates.

CPR attempts recommended Adult or child <i>[Signature]</i>	For modified CPR Child only, as detailed above	CPR attempts NOT recommended Adult or child
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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?
Assessed under mental health act assessment. Kate was unable to understand or retain information & make decisions.
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
Specialist Physiotherapist	Mary Scott	39633	MScott	9.15 10.8.23
Senior responsible clinician: Consultant	Freda Bloggs	1010	FBloggs	10.8.23 9.15

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:			
John Parr	Father	1112	optional JParr
Jane Parr	Mother	1113	JParr

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: