**ReSPECT**

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**Recommended Summary Plan for Emergency Care and Treatment for:**

Preferred name

**ReSPECT**

# Personal details

|  |
| --- |
| Full nameNHS/CHI/Health and care number |
|  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| Date of birth |
|  |
| Address |

Date completed

1. **Summary of relevant information for this plan (see also section 6)**

**ReSPECT**

**ReSPECT**

|  |
| --- |
| 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. |

1. **Personal preferences to guide this plan (when the person has capacity)**

**ReSPECT**

**ReSPECT**

For modified CPR

**Child only, as detailed above**

clinician signature

CPR attempts recommended Adult or child

clinician signature

CPR attempts **NOT** recommended Adult or child

clinician signature

**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:

How would you balance the priorities for your care (you may mark along the scale, if you wish):

**Prioritise sustaining life, Prioritise comfort,**

even at the expense even at the expense

of some comfort of sustaining life

Considering the above priorities, what is most important to you is (optional):

# Capacity and representation at time of completion

**C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old 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.

|  |
| --- |
| 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 |

1. **Involvement in making this plan**

The Clinician(s)

If D

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

1. **Clinicians’ signatures**

Senior responsible clinician

**8. Emergency contacts**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Designation (grade/speciality)** | **Clinician name** | **GMC/NMC/****HCPC Number** | **Signature** | **Date & time** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Role** | **Name** | **Telephone** | **Other details** |
| Legal proxy/parent |  |  |  |
| Family/friend/other |  |  |  |
| GP |  |  |  |
| Lead Consultant |  |  |  |

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

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

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