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

Preferred name
Annie

1. Personal details

Full name
Mrs Annette Ball

NHS/CHI/Health and care number

1	1	1	1	5	4	4	4	4	4	4	4

Date of birth 07/01/1956

Address
26 Bath Road, AB1 23C

Date completed
17/06/2017

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

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Cancer of the pancreas with spread to the liver. Initial chemotherapy not effective; does not want more. No communication difficulties.
Lives with and is the main carer for her blind husband (he is known to local social services).

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.

Referred to Palliative Care for further discussions.

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

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

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

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

Maintaining comfort. Most important to her is that her husband is cared for if she becomes too ill to help him.

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:

Intervention recommended: Hospital admission for intravenous antibiotics and blood products if she needs these.
Interventions NOT recommended: CPR. Admission to an intensive care unit. She does not want further chemotherapy to treat her cancer.

NB: If she is admitted, please contact Mrs Corrine Fairley (see emergency contacts) who will call socials services to look after Mr Ball.

CPR attempts recommended
Adult or child
clinician signature

For modified CPR
Child only, as detailed above
clinician signature

CPR attempts **NOT** recommended
Adult or child
clinician signature

ReSPECT

5. Capacity and representation at time of completion

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?
If so, document details in emergency contact section below
~~Yes~~ / No / ~~Unknown~~

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

A been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions

B where appropriate, been discussed with a person holding parental responsibility

C in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law

D been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Not applicable.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

17/06/2017 Dr Gordon Pryce discussion with Mrs Annette Ball and Mr Donald Ball; full record of discussion available on electronic health record (EMIS) at GP surgery.

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				
GP	Dr Gordon Pyrce	1111111	G Pryce	17/06/2017

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent	Not applicable		
Family/friend	Mr Donald Ball (husband)	01111 222333	
GP	Dr Gordon Pryce	01111 444555	
Lead Consultant	Dr Mark Ortiz	Bleep 155	Chemotherapy unit 5555
Other	Mrs Corrine Fairley	01111 555666	

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

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

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

Preferred name: MR AKHAND

1. Personal details

Full name: MR IMAN AKHAND

NHS/CHI/Health and care number: 1 1 1 1 1 1 1 2 2 5 5 5

Date of birth: 02/03/48

Address: 2 PETER HOUSE, G11 2GG

Date completed: 02/04/17

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

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

CHRONIC RENAL FAILURE – HAEMODIALYSIS SINCE 2016

31/03/2017 MYOCARDIAL INFARCTION

WIFE REQUIRES BENGALI INTERPRETER

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.

NONE.

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

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

Prioritise sustaining life, even at the expense of some comfort — X — **Prioritise comfort,** even at the expense of sustaining life

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

STAYING ALIVE AND BEING WITH MY FAMILY.

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:

RECOMMENDED – ALL ACTIVE TREATMENT.

CPR attempts recommended Adult or child

clinician signature

For modified CPR **Child only, as detailed above**

clinician signature

CPR attempts **NOT** recommended Adult or child

clinician signature

ReSPECT

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan?
~~Yes~~ / **No** / ~~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? If so, document details in emergency contact section below
~~Yes~~ / **No** / ~~Unknown~~

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

A been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions

B where appropriate, been discussed with a person holding parental responsibility

C in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law

D been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

—

Date, names and roles of those involved in discussion, and where records of discussions can be found:
02/04/2017 DR WATER (RENAL), DR PACE (CARDIOLOGY), SISTER BOND (CCU NURSE IN CHARGE), NAMRATA BEGUM (WIFE), RIBAT AKHAND (SON), NOORJAHAN (INTERPRETER) AND MR AKHAND. SEE NOTES ENTRY – 1300 HRS

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				
CONSULTANT (RENAL)	DR. B. WATER	3333333		02/04/17 1300

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent	—		
Family/friend	RIBAT AKHAND (SON)	07777 555555	
GP	DR ATIF BANERJEE	01111 222222	
Lead Consultant	DR B. WATER	01111 333333	
Other	NAMRATA BEGUM (WIFE)	07777 666666	USE BENGALI INTERPRETER

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

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

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

Preferred name: RYAN

1. Personal details

Full name: RYAN MOORE

NHS/CHI/Health and care number: 3 3 3 3 3 3 3 4 4 4 4 4

Date of birth: 05/03/95

Address: 7 ROYAL ROAD, JT1 1IT

Date completed: 01/08/17

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

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

01/08/17 SUBARACHNOID HAEMORRHAGE
- NOW UNCONSCIOUS, PREVIOUSLY FIT + HEALTHY

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.

NONE

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

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

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

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

N/A (SEE SECTIONS 5+6)

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below

clinician signature: P. B

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:

FOR ALL ACTIVE TREATMENTS

CPR attempts recommended Adult or child

clinician signature: P. B

For modified CPR **Child only, as detailed above**

clinician signature

CPR attempts **NOT** recommended Adult or child

clinician signature

ReSPECT

5. Capacity and representation at time of completion

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? If so, document details in emergency contact section below
~~Yes~~ / **No** / ~~Unknown~~

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

A been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions

B where appropriate, been discussed with a person holding parental responsibility

C in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law

D been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

01/08/17 9PM ~~DE~~TAILED DISCUSSIONS WITH PARENTS AS RYAN IS UNCONSCIOUS

Date, names and roles of those involved in discussion, and where records of discussions can be found:

01/08/17 9PM DR BREATH + MR MRS MOORE (PARENTS) PLEASE SEE FULL ENTRY IN ELECTRONIC HEALTH RECORD

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				
ICU CONSULTANT	DR PETER BREATH	7777777	P.B	01/08/17 9PM

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent	—		
Family/friend	JAN MOORE (MOTHER)	03333 444 555	
GP	DR SIMON HOME	03333 666 777	
Lead Consultant	DR PETER BREATH	03333 889 999	BLEEP 922
Other			

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

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

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

Preferred name: NELLIE

1. Personal details

Full name: NELLIE FROST

NHS/CHI/Health and care number: 1 1 1 1 1 2 2 2 2 2 2 3

Date of birth: 2/4/33

Address: 1, STONE STREET XN1R 2LA

Date completed: 4/7/17.

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

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

VASCULAR DEMENTIA - LACKS CAPACITY FOR DECISIONS RELATED TO HEALTH

REQUIRES HEARING AID, HAS POOR VISION

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.

NO ADRT BUT SEE SECTION 6 - SON + DAUGHTER HAVE JOINT LASTING POWER OF ATTORNEY STATUS FOR HEALTH + WELFARE

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

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

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

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

(FROM SON + DAUGHTER) BEING WARM + COMFORTABLE

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 M. Allen.

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:

RECOMMENDED - ADMISSION TO HOSPITAL ONLY IF NEEDED FOR TREATMENT of REVERSIBLE CONDITIONS CAUSING SYMPTOMS I.E INFECTION

NOT RECOMMENDED - INTENSIVE CARE UNIT ADMISSION, VENTILATION RENAL REPLACEMENT

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 M. Allen.

ReSPECT

5. Capacity and representation at time of completion

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

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

A been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions

B where appropriate, been discussed with a person holding parental responsibility

C in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law

D been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

3/7/17 ADAM FROST - SON
ANTHEA KELLERMAN - DAUGHTER
PEARL MOSS - CARE HOME MANAGER

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
COMMUNITY MATRON	MIRIAM ALLEN	1111111A	M. Allen	4/7/17
Senior responsible clinician				
GP	DR S BIRD	2222222		6/7/17(1600)

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent	ADAM FROST (SON)	} JOINT LPA FOR HEALTH + WELFARE
Family/friend	ANTHEA KELLERMAN (DAUGHTER)	} (01111) 111 555
GP	DR S BIRD	(01111) 123 123	
Lead Consultant			
Other	MRS P MOSS	(01111) 243 243	CARE HOME MANAGER

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

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