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