ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name	Miss Donotuse Xxtestpatient-Taqp
Date of birth	04 September 2008
Address	C/O Hscic Test Data Manager, Solution Assurance, 1 Trevelyan Sq., Boar Lane, Leeds, West Yorkshire. LS1 6AE
NHS/CHI/Health and care number	9 9 9 0 5 0 4 7 4 1

1. This plan belongs to:

Preferred name Donotuse

Date completed 17 April 2025

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:
Malignant neoplasm of female breast. Patient fully aware. Breast cancer. Widespread bone and liver mets. on palliative chemotherapy, problems with vomiting and severe nausea. REcent cord compression treated with radiotherapy.. HIV positive Severe COPD. Lives alone - help available. Lives in Extra Care housing. carer visits twice a day. Friendly dog.. Visual impairment. Hearing impairment. Cognitive impairme (cont.)

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):
Has ADRT (advance decision to refuse treatment) (Mental Capacity Act 2005). by fridge

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 [X] **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 — X — **Quality of life and comfort matters most to me**

What I most value:	What I most fear / wish to avoid:
I want to stay at home unless my symptoms cannot be controlled well Being around family and with my faith community	dying in hospital, being a burden to others.

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		Candida Cornish		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:
Wishes to avoid hospital admission if possible, but consider admission for urgent treatment of a reversible condition if medically indicatedConsider hospital admission for easily reversible condition with good chance of a return to good quality of life. Not for ITU or non invasive ventilation

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	3196751 Dida test 17.4.25

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?
[X] 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):

[X] **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.)
TEST if no section A dida 7.4. 26

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician: Dr Dida Test 3333333333 31.		consultant		17-04-25 12:40

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 Smith test 31.3.25	[X]	partner	07778889999	optional
Jane Smith	[X]	Daughter		optional
	[X]			optional
	[ ]			optional
John Smith dida tes 7.4.25	[ ]	partner dida tes31 3 25	07777888899 dida tes 3	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

Continuation sheet

2. Shared understanding of my health and current condition.
Summary of relevant information for this plan including diagnosis and relevant personal circumstances:
(cont.) nt. Struggles to remember recent events.. Patient does not have learning difficulties

Preferred place of care
First Preference: Preferred place of care - Home
First Preference Location:

First Preference: Preferred place of death - Hospice
First Preference Location: St PEter's Hospice