University Hospitals of Morecambe Bay NHS Foundation Trust

ALLERGIES

Name				DOB:	
Address					
				Post code:	
Hospital No.		NHS No.		Date:	

Child and Young Person's Advance Care Plan Collaborative

Collaborators: Alder Hey Children's Hospital, Dorset County Hospital, Gloucestershire Hospitals NHS Foundation Trust, Helen & Douglas House Hospices, Kent & Medway C&YP Palliative Care Network, Naomi House & Jacksplace, North Hampshire NHS Trust, North West Children's Palliative Care Network, Oxford University Hospitals NHS Trust, Poole Hospital, Portsmouth Hospitals NHS Trust, Royal Berkshire NHS Foundation Trust, Royal Manchester Children's Hospital, Solent NHS Trust, Southampton Children's Hospital, St Mary's Hospital Isle of Wight, Together for Short Lives, West Midlands Paediatric Palliative Care Network

Child and Young Person's Advance Care Plan

This document is a tool for discussing and communicating the wishes of a child, young person, parent(s) and/or their family. The plan is also designed to record the wishes of families for their baby (neonate or infant).

In addition to recording a concise record of the advance plans it is designed to provide a rapid overview, of key decisions, to the attending carers, should an emergency situation arise when the individual cannot give informed consent for themselves and / or next of kin / parent(s) cannot be contacted.

It is a collaborative document with representation including the South Central and Wessex, West Midlands, North West, Kent and the South West for shared decision making between families and clinicians.

Child & Young Person's Advance Care Plan (CYPACP)

INDEX

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Contacts

Name		Date of Birth	
Known as		Interpreter needed	○ Yes ○ No
First Language		Interpreter contact	
Home Address			
		Postcode:	
Telephone Numbers:			

Family Tree

Name of person/people with parental responsibility (and address if different from above):

Emergency contact number for person/s with parental responsibility:

Other emergency contact No.	

Others (e.g. family and friends)

Name	Relationship	Telephone numbers

Emergency contact for professional who knows child:

For use please tick [x]	Everywhere ☐	Home ☐	School ☐	Hospital ☐

Date Plan Initiated		**Date Review due**	

Date reviewed/ amended:	Name & title of lead reviewer	Expected review date (if appropriate)

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Wishes during Life

WISHES DURING LIFE
Child's / Young Person's wishes e.g. Place of care, symptom management, people to be involved (professional/non-professional), activities to be continued (spiritual and cultural).
Family wishes e.g. Where you want to be as a family, who you would like to be involved (e.g. medical, spiritual or cultural backgrounds).
Others' wishes (e.g. school friends, siblings)

This page discussed by:	
Child /Young Person / Parent / Carer Professional (full name and job title/ initials) (Initials only may be used if this page is filled out by the lead clinician)	
Date:	

Name:			
DOB:			
Hospital No.		NHS No.	

Diagnosis and Decision Making

Diagnosis

Main problems and Background information

Social issues (Include if Looked after Child)

Decision Making Process

Basis of discussion / decision-making? (Tick as appropriate) [X]

☐	Wishes of child/young person with capacity	
☐	Wishes of parent(s) for child on “best interests” basis	
☐	Best interests basis (as in Mental Capacity Act 2005)	
☐	Other (please state)	

Comment

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Specific Treatment Plans

(Prompt: allergies recorded on Front Cover)

Management of seizures *(Please select one option only)*	**Date of Weight**	**Weight (Kg)**
○ Manage using APLS guidelines		
○ Requires a personalised seizure plan below		

Personalised Seizure plan: (drug name, dose and route) please add patient weight used to calculate drug doses			
First Line		after	mins
Second Line		after further	mins
Third Line		after further	mins

Call **999** for emergency transfer to hospital?	○ Yes ○ No
If yes, at what stage	
Description of usual seizure pattern/ types	
Other instructions for seizures	

Management of infection

This section is for community use and may involve instructions to transfer to hospital.
Contact specialist team and microbiology
Please record if likely to be neutropaenic or have an immune deficiency
Preferred antibiotic or regime for recurrent infections – drug dose, route, duration:

Instructions for other specific circumstances

Name	Signature	Professional Role	Date

Management of a Life Threatening Event

Prompt: allergies recorded on Front Cover

Symptoms and signs to expect (NB Information about diagnosis is on p6)

In the event of a likely *reversible* cause for acute life-threatening deterioration such as **choking, tracheostomy blockage or anaphylaxis please intervene and treat actively.** Please also treat the following possible problems actively e.g. bleeding **(please state):**

A life threatening event may lead to a cardiac or respiratory arrest (cardiorespiratory arrest). If p15 has not been completed, decisions about resuscitation would normally be made on a 'best interests' basis. The presumption would normally be for attempted resuscitation initially unless this seemed futile, unlikely to be successful, not in best interests, or otherwise directed.

In the event of life threatening event (Add comments to clarify wishes)

✓	Support transfer to preferred place of care if possible	
✓	Maintain comfort and symptom management, and support child / young person and family	
✓	Clear upper airway / mouthcare	

○ Yes ○ No	Facemask oxygen if available.
○ Yes ○ No	Bag and mask ventilation.
○ Yes ○ No	Emergency transfer to hospital if considered appropriate.
○ Yes ○ No	Intravenous access or Intraosseous access.
○ Yes ○ No	Non-invasive ventilation.
○ Yes ○ No	Intubation.

Comments about feeds and fluids

Other (please state): (e.g. may include specific information if a life threatening emergency happens at school)

Name	Signature	Professional Role	Date

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Wishes during End of Life

WISHES AROUND THE END OF LIFE
Priorities of care including preferred place for care of child /young person
Spiritual and cultural wishes
Other child/ young person & family wishes, e.g. what happens to possessions?
Organ & tissue donation (see separate guidance on web link http://www.organdonation.nhs.uk) National contact numbers. 0300 123 2323 Regional contact numbers.
Funeral preferences Seek detailed information or further advice if needed

This page has been discussed with child / young person/ parent/ carer:	Professional: (full name and job title/initials)	Date
If page not completed please comment on reasons		

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Signature Page

Note the signatures apply to pages 4 - 9 only

Who has agreed and supports the plan?

(Doctors must add GMC number after the signature)

Lead Clinician			
Name			
Professional Registration Number		Role:	
Signature		Date:	

Others included in the decision making. (also see p 14)

Young Person
(if appropriate; optional) (to ensure their opinions have been included in the decision making)

Name	Signature	Date

Person/ Persons with parental responsibility (see page 4)
(to ensure their opinions have been included in the decision making)

	Name	Signature	Role	Date
1				
2				
3				
4				
Other				
1				
2				
3				

Clinicians have a duty to act in a patient's best interests at all times.

If a parent or legal guardian is present at the time of their child's collapse, they may wish to deviate from the previously agreed plan and under these circumstances their wishes should be respected, provided they are thought to be in the best interests of the child/ young person. The child/young person or parents /guardian can change their mind about any of the preferences on the care plan at any time.

Name:			
DOB:			
Hospital No.		NHS No.	

Additional Notes

Name:			
DOB:			
Hospital No.		NHS No.	

Additional Notes

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Distribution List (Key Contacts)

The co-ordinator is responsible for the distribution of the CYPACP, for bringing it to the attention of professionals, and for circulating any updates to it:	
Name of Co-ordinator	Contact Details

24 hour contact number available: (record p14)	○ Yes ○ No

NB: The child and family will hold a full copy of their plan
A full photocopy of the plan to: (include date sent and by whom)

		Name and contact details	Date sent and by whom
☐	Local Emergency Department		
☐	Children's Community Nursing Team		
☐	Hospice		
☐	Lead Paediatrician (refer to p14 for specialists involved)		
☐	GP		
☐	Other		
☐	Other		

Other professionals who require either a full photocopy, or need to be made aware that the child has a plan (please state which):

Full photocopy= Aware of plan=	FP / A	Name and contact details	Date sent and by whom
Hospital (ward or assessment unit)			
Respite /Short Break Care provider			
GP Out of Hours			
Ambulance Control			
School Nurse			
School			
Transition			
Social Services			
Other (e.g. CDOP, Coroner, or EOL Register)			
Other (e.g. Hospital Specialists see p14 for contact details; list specialties only here)			

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

If the child / young person dies

(Please contact the following people)

Co-ordinator responsible for the distribution of the CYPACP and bringing to the attention of professionals that the child has a plan.

24 hour contact number available:	○ Yes ○ No	**Phone No.**	

		Name and contact details
☐	Parents/Guardians	
☐	General Practitioner	
☐	Lead Paediatrician	
☐	Hospice	
☐	Organ and Tissue Donation team	
☐	Other (Rapid Response Team)	
☐	Other (ED/ Childrens Ward)	
☐	Other	
☐	Other	

Other professionals who have either a full photocopy (FP), or are aware (A) that the child has a plan (please see page 13 and below).

NB Where multiple hospital specialists are involved in care it is the responsibility of the lead paediatrician/ lead clinician to inform them of the death; please list names and speciality below and name of person who will inform them.

University Hospitals of Morecambe Bay NHS Foundation Trust

Name:			
DOB:			
Hospital No.		NHS No.	

Management of Cardiorespiratory Arrest

(Including DNACPR)* ***Delete if not appropriate**

Child's Name		**NHS No.**	

☐ **Cardiopulmonary Resuscitation status (CPR) has not been discussed**
attempt CPR unless clearly not in the best interest of the child/ young person (Only a senior clinician may make this decision)

☐ **Cardiopulmonary Resuscitation status has been discussed and the following has been agreed:**

Diagnosis and reason(s) for decision (also see p6)

Ambulance Directive

Clearly strike through unused boxes in dark ink as appropriate (only 1 box to be active)

Attempt full Cardiopulmonary Resuscitation

OR

Attempt Cardiopulmonary Resuscitation with modifications below:

OR

DO NOT attempt Cardiopulmonary Resuscitation DNACPR

Select	Select	Select
Attempt CPR as per Resuscitation Council (UK) guidelines.	INTUBATION: Yes / No AIRWAY AND BREATHING CIRCULATION PICU: Yes / No	**DNACPR** Patient-specific supportive care is documented on pages 7, 8 and 9

Clinician (usually lead clinician)		**2nd Clinician** (2nd Signature may be required if lead clinician has not signed above and countersigns at a later date)	
Clinician Name		Clinician Name	
Professional Role/ Grade		Professional Role/ Grade	
GMC/ (NMC) No.		GMC/ (NMC) No.	
Signature		Signature	
Date		Date	

Name:			
DOB:			
Hospital No.		NHS No.	

www.cypacp.nhs.uk

Version 1.1

Review date: December 2018

Please note exceeding this date does not invalidate the information contained in this proforma. However this version should not be used to record a new CYPACP after this date.