

ALLERGIES

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



Child and
 Young Person's
Advance Care Plan
 Collaborative



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)

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Name:			
DOB:			
Hospital No.		NHS No.	

Contacts

Name			Date of Birth	
Known as			Interpreter needed	<input type="radio"/> Yes <input type="radio"/> 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)

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]

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Wishes of child/young person with capacity |
| <input type="checkbox"/> | Wishes of parent(s) for child on "best interests" basis |
| <input type="checkbox"/> | Best interests basis (as in Mental Capacity Act 2005) |
| <input type="checkbox"/> | Other (please state) |

Comment

Name:			
DOB:			
Hospital No.		NHS No.	

Specific Treatment Plans

(Prompt: allergies recorded on Front Cover)

Management of seizures <i>(Please select one option only)</i>	Date of Weight	Weight (Kg)
<input type="radio"/> Manage using APLS guidelines		
<input type="radio"/> 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

Name:			
DOB:			
Hospital No.		NHS No.	

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)

- | | | |
|-------------------------------------|--|--|
| <input checked="" type="checkbox"/> | Support transfer to preferred place of care if possible | |
| <input checked="" type="checkbox"/> | Maintain comfort and symptom management, and support child / young person and family | |
| <input checked="" type="checkbox"/> | Clear upper airway / mouthcare | |

- | | |
|--|---|
| <input type="radio"/> Yes <input type="radio"/> No | Facemask oxygen if available. |
| <input type="radio"/> Yes <input type="radio"/> No | Bag and mask ventilation. |
| <input type="radio"/> Yes <input type="radio"/> No | Emergency transfer to hospital if considered appropriate. |
| <input type="radio"/> Yes <input type="radio"/> No | Intravenous access or Intraosseous access. |
| <input type="radio"/> Yes <input type="radio"/> No | Non-invasive ventilation. |
| <input type="radio"/> Yes <input type="radio"/> 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

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 		

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

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
<input type="checkbox"/>	Local Emergency Department	
<input type="checkbox"/>	Children's Community Nursing Team	
<input type="checkbox"/>	Hospice	
<input type="checkbox"/>	Lead Paediatrician (refer to p14 for specialists involved)	
<input type="checkbox"/>	GP	
<input type="checkbox"/>	Other	
<input type="checkbox"/>	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)				

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:	<input type="radio"/> Yes	<input type="radio"/> No	Phone No.	
--	---------------------------	--------------------------	------------------	--

		Name and contact details
<input type="checkbox"/>	Parents/Guardians	
<input type="checkbox"/>	General Practitioner	
<input type="checkbox"/>	Lead Paediatrician	
<input type="checkbox"/>	Hospice	
<input type="checkbox"/>	Organ and Tissue Donation team	
<input type="checkbox"/>	Other (Rapid Response Team)	
<input type="checkbox"/>	Other (ED/ Childrens Ward)	
<input type="checkbox"/>	Other	
<input type="checkbox"/>	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.

--

Name:	
DOB:	
Hospital No.	NHS No.

Management of Cardiorespiratory Arrest

(Including DNACPR)*

*Delete if not appropriate

Child's Name		NHS No.	
<input type="checkbox"/>	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)		
<input type="checkbox"/>	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								
<input type="radio"/> Select		<input type="radio"/> Select		<input type="radio"/> Select								
Attempt CPR as per Resuscitation Council (UK) guidelines. -----		<table border="1"> <tr> <td>INTUBATION</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td>AIRWAY AND BREATHING</td> <td></td> </tr> <tr> <td>CIRCULATION</td> <td></td> </tr> <tr> <td>PICU</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> </table>	INTUBATION	<input type="radio"/> Yes <input type="radio"/> No	AIRWAY AND BREATHING		CIRCULATION		PICU	<input type="radio"/> Yes <input type="radio"/> No		DNACPR Patient-specific supportive care is documented on pages 7, 8 and 9 -----
INTUBATION	<input type="radio"/> Yes <input type="radio"/> No											
AIRWAY AND BREATHING												
CIRCULATION												
PICU	<input type="radio"/> Yes <input type="radio"/> No											

Clinician (usually lead clinician)		2nd Clinician (2 nd 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.	

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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.