

|  |
| --- |
| **ALLERGIES** |
| Enter details here |

**­­­­­**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | Patient's name | | | | DOB: | 01/01/1902 |
| Address | Address Line1 | | | | | |
|  | Address Line2 | | | | | |
|  | Address Line3 | | | Post code: | | M19 20 |
| Hospital No. | 0123456 | NHS No. | 012345 | | Date: | (dd/mm/yyyy) |





Interim Version 2.0

Incorporating ReSPECT

**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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# Contacts

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | **Patient's name** | Date of Birth | **01/01/1902** | | | |
| Known as |  | Interpreter needed |  | Yes |  | No |
| First Language |  | Interpreter contact |  | | | |
| Home Address | Address Line1 | | | | | |
| Address Line2 | | | | | |
| Address Line3 | Postcode: | M19 20 | | | |
| 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** | dd/mm/yyyy | **Date Review due** | dd/mm/yyyy |

|  |  |  |
| --- | --- | --- |
| Date reviewed/ amended: | Name & title of lead reviewer | Expected review date (if appropriate) |
| dd/mm/yyyy |  | dd/mm/yyyy |
| dd/mm/yyyy |  | dd/mm/yyyy |
| dd/mm/yyyy |  | dd//mm/yyyy |
| dd/mm/yyyy |  | dd/mm/yyyy |

# 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: | name |
| **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: | dd/mm/yyyy |

# 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) | Other |
| **Comment** | | |
|  | | |

# 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 | dd/mm/yyyy | Kg |
|  | 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 time in mins | mins |
| Second Line |  | after further time in mins | mins |
| Third Line |  | after further time in mins | 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 | Signature | Role | dd/mm/yyyy |

# 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 | Specify |
| **🗸** | Maintain comfort and symptom management, and support child / young person and family | Specify |
| **🗸** | Clear upper airway / mouthcare | Specify |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
|  | Yes |  | No | Facemask oxygen if available. any comment |
|  | Yes |  | No | Bag and mask ventilation. any comment |
|  | Yes |  | No | Emergency transfer to hospital if considered appropriate. any comment |
|  | Yes |  | No | Intravenous access or Intraosseous access. any comment |
|  | Yes |  | No | Non-invasive ventilation. any comment |
|  | Yes |  | No | Intubation. any comment |
| **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 | Signature | Role | dd/mm/yyyy |

# 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 number**s**. 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 |
|  |  | dd/mm/yyyy |
|  | | |
| If page not completed please comment on reasons | | |
|  | | |
|  | | |

# 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: | dd/mm/yyyy |

|  |  |  |
| --- | --- | --- |
| **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 |
| Name |  | dd/mm/yyyy |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Person/ Persons with parental responsibility (see page 4)**  (to ensure their opinions have been included in the decision making) | | | | |
| Name | | Signature | Role | Date |
| 1 |  |  |  | dd/mm/yyyy |
| 2 |  |  |  | dd/mm/yyyy |
| 3 |  |  |  | dd/mm/yyyy |
| 4 |  |  |  | dd/mm/yyyy |
| Other | | | | |
| 1 |  |  |  | dd/mm/yyyy |
| 2 |  |  |  | dd/mm/yyyy |
| 3 |  |  |  | dd/mm/yyyy |

**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.

|  |
| --- |
| Additional Notes |
| details |

|  |
| --- |
| Additional Notes |
| details |

# 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 |  | | | | | dd/mm/yyyy  by | |
|  | Children’s Community Nursing Team |  | | | | | dd/mm/yyyy  by | |
|  | Hospice |  | | | | | dd/mm/yyyy  by | |
|  | Lead Paediatrician  (refer to p14 for specialists involved) |  | | | | | dd/mm/yyyy  by | |
|  | GP |  | | | | | dd/mm/yyyy  by | |
|  | Other |  | | | | | dd/mm/yyyy  by | |
|  | Other |  | | | | | dd/mm/yyyy  by | |

**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) |  |  | dd/mm/yyyy  by |
| Respite /Short Break Care provider |  |  | dd/mm/yyyy  by |
| GP Out of Hours |  |  | dd/mm/yyyy  by |
| Ambulance Control |  |  | dd/mm/yyyy  by |
| School Nurse |  |  | dd/mm/yyyy  by |
| School |  |  | dd/mm/yyyy  by |
| Transition |  |  | dd/mm/yyyy  by |
| Social Services |  |  | dd/mm/yyyy  by |
| Other  (e.g. CDOP, Coroner, or EOL Register) |  |  | dd/mm/yyyy  by |
| Other (e.g. Hospital Specialists see p14 for contact details; list specialties only here) |  |  | dd/mm/yyyy  by |

# If the child / young person dies (Urgent Contact List)

**(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. | | | | | | |
| Details | | | | | | |
| **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.** |
|  |

**Recommended Summary Plan for Emergency Care & Treatment**

# Management of Cardiorespiratory Arrest

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1** | **Preferred Name**: |  | **Date completed**: | (dd/mm/yyyy) |
| **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. | | | | |
| 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. | | | | |

|  |  |
| --- | --- |
| **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): | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Considering the above priorities, what is most important to you is (optional): | | |
| **4** | Clinical recommendations for emergency care and treatment | |
|  |  |  |
| 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**:** | | |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| CPR attempts recommended | For modified CPR  (as detailed above) | CPR attempts NOT recommended |
| Clinician signature | Clinician signature | Clinician signature |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: (select 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 selected, 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**:** | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **7** | Clinicians’ signatures | | | | | | |
| Designation  (grade/speciality) | | Clinician name | GMC/ NMC/ HCPC Number | Signature | | Date & time | |
|  | |  |  |  | |  | |
|  | |  |  |  | |  | |
| Senior responsible clinician: | | | | | | | |
|  | |  |  | |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **8** | Emergency contacts | | | |
| Role | | Name | Telephone | Other details |
| Legal proxy/parent | |  |  |  |
| Family/friend | |  |  |  |
| GP | |  |  |  |
| Lead Consultant | |  |  |  |
| Other | |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **9** | Confirmation of validity (e.g. for change of condition) | | | | |
| Review date | | Designation (grade/speciality) | Clinician name | GMC/ NMC/ HCPC No. | Signature |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |