

|  |  |
| --- | --- |
| Endorsed by NICE | This plan could begin antenatally |

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

|  |  |  |  |
| --- | --- | --- | --- |
|  Name | Patient’s full name |  DOB | DOB |
|  Address |   |
|  |
|   |  Post code |   |
|  NHS No. | NHS number |  Hospital No. |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **For use** (indicate as appropriate) | Everywhere [ ]  | Home [ ]  | School [ ]  | Hospital [ ]  | Hospice [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date plan initiated** | *dd/mm/yyyy* | **Date review due** (if appropriate) | *dd/mm/yyyy* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date reviewed | Designation(grade/speciality) | Clinician name | GMC/NMC/ HCPC number  | Signature |
| *dd/mm/yyyy* | Designation | *Name* | *GMC/NMC/HCPC* | *Signature* |
| *dd/mm/yyyy* | Designation | *Name* | *GMC/NMC/HCPC* | *Signature* |
| *dd/mm/yyyy* | Designation | *Name* | *GMC/NMC/HCPC* | *Signature* |

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|  | http://cypacp.uk/ | Version 4 (Legacy Version) |

**Child and Young Person’s Advance Care Plan**

This document is a tool for discussing and communicating the wishes of an infant, child, young person and/or their parent or carer. It is a collaborative document for shared decision-making between families and clinicians.

In addition to recording a concise record of the advance plans, this document 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. This is particularly helpful if next of kin / parent(s) are not present immediately.

The document has had input and support from English regions including: South Central and Wessex, South West, West Midlands, East Anglia, Kent and Sussex, London, North West, and the North East. The content of this care plan accurately reflects the NICE guideline on end of life care for infants, children and young people with life-limiting conditions. (NG61, 2016 and QS160). It also supports statement 1 in the NICE quality standard for end of life care for infants, children and young people. Version 4 is endorsed by NICE (E193) (2018).

For electronic copies of this form, information leaflets and associated guidance, see the CYPACP website: <http://cypacp.uk/>

|  |  |
| --- | --- |
| Lead Clinician | **­**  *Lead clinician*  |
| Contact details |  *Contact details*  |

|  |  |
| --- | --- |
| 24 hr contact phone number(if available) |  ***Enter 24 hr contact phone number***  |
| What is this number? e.g. Ward, community nursing team, on call team or hospice? | *Details* |

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

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# Contacts and who has agreed and supports this plan

|  |  |  |  |
| --- | --- | --- | --- |
| Name  | Patient’s full name | Date of Birth | DOB |
| Known as |  | Interpreter needed? | *Yes/No* |
| First Language | *1st Language* | Interpreter contact | *Contact* |
| Telephone Numbers: | *Telephone* |

|  |
| --- |
| **Name and emergency contact number of person/people with parental responsibility** (and address if different from front page) |
|  |
| **Other key family members** and carers (optional)**:** |
|  |

**Who has agreed and supports the plan?**

|  |
| --- |
| **Lead Clinician** |
| Name | *Name* |
| Role | *Role* | Professional registration no.  |   |
| Signature | *Signature* | Date: | *dd/mm/yyyy* |

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| **Young Person and person/people with parental responsibility**  |
| Please note that in recording names below, this indicates that the person/ people with parental responsibility, and the young person where appropriate, are aware of the plan and in agreement with it. (The signatures below are optional but help ensure their opinions have been included in the decision-making). |
|  |
| **Young Person (where appropriate; signature optional)** |
| Name | Signature | Date |
| *Name* | *Signature* | *dd/mm/yyyy* |
| **Person/ People with parental responsibility (signature optional)**  |
| Name | Signature | Role | Date |
| 1 | *Name* | *Signature* | *Role* | *dd/mm/yyyy* |
| 2 | *Name* | *Signature* | *Role* | *dd/mm/yyyy* |
| **Others involved in decision-making, for example Multi-Disciplinary Team (MDT)** |
|  |
| The young person or parents /carer can change their mind about any of the preferences on the care plan at any time. If a parent /person with parental responsibility 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**.** |

# Diagnosis and Decision-making

|  |
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| **Diagnoses** |
|  |
| **Main problems and background information** |
|  |
| **Social issues**  (Include if looked-after child) |
|  |

|  |
| --- |
| **Decision-making process** (Select at least one)**Basis of discussion / decision-making?** (Indicate 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** |
|  |
| **Clinicians have a duty to act in a patient’s best interests at all times.** |

# Distribution list (Key Contacts)

|  |
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| Who is responsible for the distribution of the CYPACP, bringing it to the attention of professionals, and circulating any updates to it? |
| Name and/or Role | Contact Details |
| *Name & Role* | *Contact detail* |

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| **NB: The child and family will hold a full copy of their plan****A full photocopy of the plan also to:** (include date sent and by whom) |
| Full copy=Aware of plan= | FC/A | Name and contact details | Date sent and by whom |
| [ ]  | Local Emergency Department | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Children’s Community Nursing Team | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Hospice | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Lead Paediatrician | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | GP | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Hospital (ward or assessment unit) | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Respite / Short Break Care provider | *FC/A* | *Name and contact details* | *By* *dd/mm/yyyy**By* |
| [ ]  | GP Out of Hours | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Ambulance Control | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | School Nurse / Head Teacher | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Social Services | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Other (e.g. Hospital Specialists ) | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Other | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Other | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Other | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |
| [ ]  | Other | *FC/A* | *Name and contact details* | *dd/mm/yyyy**By* |

|  |
| --- |
| **Comments** |

# Wishes during Life

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| **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 (including spiritual and cultural) and goal-directed outcomes. |
|  |
| **Family wishes** e.g. Where you want to be as a family, who you would like to be involved, sibling needs (e.g medical, spiritual or cultural backgrounds). |
|  |
| **Others’ wishes** (e.g. siblings, school friends) |
|  |

# Wishes around End of Life (Optional)

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

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| If page not completed please comment  |
|  |

# Management of Anticipated Complications (Allergies recorded on Front Cover)

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Weight** | **Weight (Kg)** |  | This section should be used to record plans for specific circumstances which might be encountered e.g. management of chest infections. Where a management plan already exists (e.g. seizure management plan) it should be signposted |
| *dd/mm/yyyy* | *weight* |  |

|  |
| --- |
| **Instructions for specific circumstances** |
| For example seizures: manage as per Advanced Paediatric Life Support (APLS) Guidelines, or may require a personalised seizure plan as signposted here. Include below as to if, or when, to call 999 and transfer to hospital. |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Signature | Professional Role | Date |
| *Name* | *Signature* | *Role* | *dd/mm/yyyy* |

#

# Additional Notes

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# Management of an Acute Significant Deterioration (non-arrest)

 **Prompt: allergies recorded on Front Cover |**

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| 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):** |
|  |
| An acute deterioration may lead to a cardiorespiratory arrest. If a decision about CPR has not been made then the default is to attempt resuscitation unless this would be futile, unlikely to be successful or not in the child’s best interests. |

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|  **In the event of life threatening event provide the following care** (Add patient-specific detail below) |
| **🗸** | Support transfer to preferred place of care if known and possible | *Specify* |
| **🗸** | Maintain comfort and symptom management, and support child / young person and family | *Specify* |
| **🗸** | Clear upper; airway / mouthcare | *Specify* |

|  |
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|  |
| [ ]  | Yes | [ ]  | No | Facemask oxygen if available. *any comment* |
| [ ]  | Yes | [ ]  | No | Bag and mask ventilation or mouth to mouth ventilation. *any comment*  |
| [ ]  | Yes | [ ]  | No | Emergency transfer to hospital if considered appropriate. *any comment* |
| [ ]  | Yes | [ ]  | No | Intravenous access. *any comment* |
| [ ]  | Yes | [ ]  | No | Intraosseous access. *any comment* |
| [ ]  | Yes | [ ]  | No | Non-invasive ventilation/Optiflow. *any comment* |
| [ ]  | Yes | [ ]  | No | Intubation *any comment* |
| [ ]  | Yes | [ ]  | No | Admission to Intensive Care (where medically appropriate) *any comment* |
| [ ]  | Yes | [ ]  | No | Other: *any comment* |
| **Comments about feeds and fluids** |
|  |
| **Other (please state):** (e.g. may include specific information if a life-threatening emergency happens at school) |
|  |

# Management of Cardiorespiratory Arrest (may Include DNACPR)

**\*Delete if not appropriate**

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Name** | Patient’s full 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** |
|  |  |  |  |  |
| Attempt CPR as per Resuscitation Council (UK) guidelines.- - - - - - - - - - - - - - |  | INTUBATION |  |  |  | **DNACPR**Patient-specific supportive care is documented on pages 7, 8 and 9- - - - - - -- - - - - - - - |
|  | AIRWAY AND BREATHING |   |  |
|  | CIRCULATION |   |  |
|  | ICU |  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **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 | *Name* | Clinician Name | *Name* |
| Professional Role/ Grade | *Role* | Professional Role/ Grade | *Role* |
| GMC/ (NMC) No. | *GMC/NMC* | GMC/ (NMC) No. | *GMC/NMC* |
| Signature | *Signature* | Signature | *Signature* |
| Date | *dd/mm/yyyy* | Date | *dd/mm/yyyy* |