Child and Young Person's Advance Care Plan Collaborative

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*

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*

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Section 1: Contacts, Demographics and Decision- making

Section 2: Wishes

Section 3: Emergency Medical Management

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*

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

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)

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*

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

Name: Patient's full name

NH 11233 DOB:

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 (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)

Name: Patient's full name

NH 11233 DOB:

Wishes around End of Life (Optional)

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 2323 Regional 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

If page not completed please comment

Name: Patient's full name

NHS No: DOB:

Management of Anticipated Complications (Allergies recorded on Front Cover)

Date of Weight	Weight (Kg)
dd/mm/yyyy	*weight*

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

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

Name: Patient's full name

NHS No: DOB:

Management of an Acute Significant Deterioration (non-arrest)

Prompt: allergies recorded on Front Cover |

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.

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*

☐	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)

Name: Patient's full name
NHS No: DOB:

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**
○ Select		○ Select		○ Select
Attempt CPR as per Resuscitation Council (UK) guidelines.		INTUBATION ○ Yes ○ No AIRWAY AND BREATHING CIRCULATION ICU ○ 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	*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*