**Advance Care Plan for a Child or Young Person**

This document is a tool for discussing and communicating the wishes of a child / parent(s) or young person. It is particularly useful in an emergency, when the individual cannot give informed consent for themselves and / or next of kin / parent(s) cannot be contacted.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Known As:</td>
<td>Hospital No.</td>
</tr>
<tr>
<td>First Language:</td>
<td>NHS Number:</td>
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</table>

Home Address:  

Postcode:  

Telephone Number:

NB: If the child or young person becomes unwell and needs an ambulance, inform ambulance control that the child has an Advance Care Plan. Ambulance Control will have an electronic copy of the ACP flagged under the child's home address and postcode. Don't forget to give ambulance control the child or young person's current location as well, if they are away from home.

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

Emergency contact number for person with parental responsibility: ___________________________

Other emergency contact numbers: ___________________________

Other key people (e.g. family and friends): ___________________________

Name: ___________________ Relationship: ___________ Tel: ___________

Name: ___________________ Relationship: ___________ Tel: ___________

Primary diagnosis and background summary:

Advance Care Plan for Use In:  

☐ Home  ☐ School  ☐ Hospital  ☐ Hospice  ☐ Other: ___________________________

Date Plan Initiated ___________________ Date Review is due ___________________

<table>
<thead>
<tr>
<th>Date reviewed/amended:</th>
<th>Name &amp; Title of Lead Reviewer</th>
<th>Next Review Date</th>
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</tbody>
</table>
Advance Care Plan: Intercurrent illness/acute deterioration continued

Name: __________________________ Date of Birth: ____________ NHS No. ____________

Address: ________________________________________________________________

Specific treatment plans if indicated

Management of seizures
Description of usual seizure pattern / types: ______________________________________

Rescue medication: (drug name, dose and route)

<table>
<thead>
<tr>
<th>First line</th>
<th>After mins</th>
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</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Second Line</th>
<th>After mins</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Third Line</th>
<th>After mins</th>
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<tbody>
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</tbody>
</table>

Call 999 for emergency transfer to hospital? Yes No (Delete)
If yes, at what stage? __________________________________________
Other instructions for seizures: ____________________________________

Management of infection (check for known allergies)
Preferred antibiotic or regime for recurrent infections – drug dose, route, duration:

______________________________________________________________

Intravenous antibiotics will normally require transfer to hospital for investigation and initiation of treatment.

Other instructions/comments regarding infection-related symptoms e.g. nebulisers, steroids.

______________________________________________________________

Instructions for emergency care in other specific circumstances:
(Document here regimes specific to this child/young person, for example for management of metabolic disturbance etc).
Advance Care Plan: Intercurrent illness / acute deterioration

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):

If a cardiac or respiratory arrest is not specifically anticipated, decisions about resuscitation would normally be made on a ‘best interests’ basis at the time of such an event. Unless a separate resuscitation section has been completed, 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 acute deterioration:
Clearly DELETE all options NOT required. (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
• Clear upper airway
• Face mask oxygen
• Bag and mask ventilation
• Emergency transfer to hospital if doctor considers appropriate in the specific situation
• Intravenous access or intraosseous access
• Consider nasogastric feeding tube (insertion or removal)
• Non-invasive ventilation
• Intubation

Other: please state:

Name: ______________________________ Date of Birth: __________________

Address: ______________________________ Known Allergies: ________________

Main Diagnoses _______________________________________________________

Signs/Symptoms to expect: ____________________________________________
Advance Care Plan: Management of cardio-respiratory arrest

Name: ____________________________ Date of Birth: _____________ NHS No. _____________

Address: ______________________________________________________________________

Regardless of the patient’s resuscitation status, the following immediately reversible causes should be treated: **choking, anaphylaxis, blocked tracheostomy tube, other:**

**RESUSCITATION STATUS**

- Resuscitation status has not been discussed – attempt full resuscitation
- Resuscitation status has been discussed and the following has been agreed:

Clearly DELETE actions NOT required

<table>
<thead>
<tr>
<th>For full resuscitation</th>
<th>Attempt resuscitation with modifications below</th>
<th>Do not attempt cardiopulmonary resuscitation DNACPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation as per standard RC(UK) guidelines</td>
<td>Patient-specific modifications to standard resuscitation guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Airway:</td>
<td>Patient-specific supportive care is documented on pages 2 and 3</td>
</tr>
<tr>
<td></td>
<td>Breathing:</td>
<td>In the event of sudden death 24 hour emergency number for doctor who knows the child:</td>
</tr>
<tr>
<td></td>
<td>Circulation:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td></td>
<td>Drugs:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PICU/HDU:</td>
<td></td>
</tr>
</tbody>
</table>

Ambulance directive: (eg Transfer to Home/Ward/Emergency Department /Hospice)

________________________________________________________

Reason(s) for decision

Senior Clinician Name: ____________________________ Signature: ____________________________

GMC No: ______________________________________________________________________

Name: ____________________________ Relationship: ____________________________

Parent/Guardian/Child/Witness Signature: ____________________________

Date Initiated: ____________________________ Review Date (see page 1): ____________________________

Photocopies may be made of this page but must have the word “PHOTOCOPY” written clearly at the top. The original copy of the document must be signed in black ink by a senior clinician and a second person and given to the family. The second person can be the person with parental responsibility or a witness e.g patient’s nurse if a family member agrees with the plan but feels unable to sign the document

Fax copy of form to Special Patient Notes Team: Ambulance Control - Fax 0845 608 0279
Send a copy to the Resuscitation Department for hospital in-patients.
Advance Care Plan: Wishes

Name: ____________________________ Date of Birth: ____________________________

Address: ________________________________________________________________

### 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): ______________________________

________________________________________

Date: __________________________________________
### Advance Care Plan: Wishes

Name: ____________________________ Date of Birth: ____________________________

Address: ________________________________________________________________

<table>
<thead>
<tr>
<th>WISHES AROUND THE END OF LIFE</th>
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<tbody>
<tr>
<td><strong>Preferred place of care of child / young person</strong></td>
</tr>
<tr>
<td><strong>Funeral preferences</strong></td>
</tr>
<tr>
<td>Seek detailed information or further advice if needed</td>
</tr>
<tr>
<td><strong>Spiritual and cultural wishes</strong></td>
</tr>
<tr>
<td><strong>Other child / young person &amp; family wishes, e.g. what happens to possessions?</strong></td>
</tr>
<tr>
<td><strong>Organ &amp; tissue donation</strong></td>
</tr>
</tbody>
</table>

This page discussed by:

Child / Young Person / Parent / Carer: ____________________________
Professional (full name and job title): ____________________________

Date: ____________________________
Advance Care Plan: Decision making

Name: ___________________________________________ Date of Birth: ___________________________

Address ______________________________________________________________________________________

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

☐ 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) __________________________________________________________

Comments: ___________________________________________________________________________________

Consider the following questions. For detailed responses use free text below

• What do you/the child/young person know about this condition, any recent changes, and anticipated prognosis?

• What do siblings understand about the condition and anticipated prognosis?

• What involvement is appropriate / possible for the child/young person in decision-making?

• To what extent has the child/young person been involved in decision-making in this area?

• What does the child/young person know about what decisions have been taken?

• Have these wishes been discussed elsewhere? In order to enhance continuity of care please attach documentation arising from any such discussions.

• For older children and young people consider the arrangements to be made for transition from paediatric to adult services

Communications and discussions

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________
Advance Care Plan

Who has agreed and supports the plan?

Name: ___________________________ Date of Birth: __________________

Address: ___________________________

Senior Clinician – I support this care plan

Name: __________________ Signature: __________________________

GMC No: __________________ Date: __________________________

Child / Young person – I have discussed and support this care plan (optional)

Name: __________ Signature: __________________ Date: __________

Parent/Guardian – We / I have discussed and support this care plan (optional)

Name: __________ Signature: __________________ Date: __________

Other - I have discussed and support this care plan

Name: __________ Signature: __________________ Date: __________

Other - I have discussed and support this care plan

Name: __________ Signature: __________________ Date: __________

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 Advance Care 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.

Communications and discussions

Photocopies may be made of the advanced care plan but must have the word “PHOTOCOPY” written clearly on the front page. The original copy of the document must be signed in black ink by a senior clinician and a second person and given to the family. The second person can be the person with parental responsibility or a witness e.g. patient’s nurse if a family member agrees with the plan but feels unable to sign the document.
Name: __________________________ Date of Birth: _______________________

Address: ____________________________________________________________

<table>
<thead>
<tr>
<th>ACP Co-ordinator – responsible for distributing this Advance Care Plan.</th>
<th>Name and contact details</th>
</tr>
</thead>
</table>

**A photocopy of this ACP is held by:**

- [ ] Parents/guardians
- [ ] General practitioner
- [ ] Paediatrician (Community)
- [ ] Paediatrician
- [ ] Hospital (e.g. Local Emergency Department and/or open access ward)
- [ ] Birmingham Children’s Hospital Emergency Department
- [ ] Hospice (please provide the name of the hospice)
- [ ] Community Nurses (CCN)
- [ ] CCN Specialist Nurses/School Nurse
- [ ] GP Out of Hours Service
- [ ] Ambulance Control
- [ ] Emergency Dept
- [ ] School-Head Teacher (with consent to share with school staff)
- [ ] Other e.g. Social Care, Short break care provider
- [ ] Adult Services/Transition Team
- [ ] Other
- [ ] Other

If you receive this page as a fax; please send receipt back
Notes: