Name: ELCH Hospital Number: NHS Number: DOB:

EVELINA LONDON EMERGENCY CARE PLAN

DATE PATHWAY INITIATED:

PATIENT INFORMATION:

PATIENT'S NAME:	KNOWN AS:
FIRST LANGUAGE:	PATIENT CAPACITY (please circle): Yes No Unknown To be determined
ELC HOSPITAL NUMBER:	NHS NUMBER:
DATE OF BIRTH:	TELEPHONE NUMBERS:
PARENT/ LEGAL GUARDIAN (please circle as appropriate & document name): MOTHER: FATHER: FOSTER CARER: OTHER:	ADDRESS:

PRIMARY DIAGNOSIS/ BACKGROUND SUMMARY:

KEY PROFESSIONALS INVOLVED:

NAME	DESIGNATION	CONTACT DETAILS

REVIEW OF DOCUMENTATION:

DATE REVIEWED/ AMENDED:	NAME , SIGNATURE & DESIGNATION OF RENEWER:	SIGNATURE & NAME OF PARENT	NEXT REVIEW DUE:

Name: ELCH Hospital Number: NHS Number: DOB:

A. ACUTE DETERIORATION

In the event of a sudden collapse with respiratory and/ or cardiac arrest, signs/symptoms to expect:

Altered conscious level: Altered colour: Altered respiratory effort/ pattern: Other:

Circle yes/ no/ discuss at the time on all options and complete blanks as appropriate:

		Decision:	Comment:
1.	Comfort and support the child and family…..		
2.	Suction upper airway	Yes No Discuss at time	
3.	Oxygen (if available)	Yes No Discuss at time	
4.	Airway positioning manoeuvres	Yes No Discuss at time	
5.	Insertion of nasopharyngeal/ oral airway	Yes No Discuss at time	
6.	Mouth to mouth/ Bag and mask ventilation for…..minutes	Yes No Discuss at time	
7.	Endotracheal intubation and ventilation	Yes No Discuss at time	
8.	External cardiac compressions	Yes No Discuss at time	
9.	Advanced life support with drugs and IV or IO access	Yes No Discuss at time	
10.	Transfer to:	A&E, Ward, Home, Hospice	

Additional information:

	Name/ service:	Date:
Discussed with PICU:		
Discussed with Subspecialty Consultant(s):		
Ambulance directive:		

Name: ELCH Hospital Number: NHS Number: DOB:

B. GRADUAL DETERIORATION

In the event of a life threatening deterioration, signs/symptoms to expect:

Altered conscious level: Altered colour: Altered respiratory effort/ pattern: Other (delete / amend as appropriate): Chest infection Other infection Gut failure Seizure escalation

Circle yes/ no/ discuss at the time on all options and complete blanks as appropriate:

		Decision:	Comment:
1.	Comfort and support the child and family…..		
2.	Suction upper airway	Yes No Discuss at time	
3.	Oxygen (if available)	Yes No Discuss at time	
4.	Increase oxygen until comfortable	Yes No Discuss at time	
5.	Oral (enteral) antibiotics	Yes No Discuss at time	
6.	Intravenous antibiotics	Yes No Discuss at time	
7.	Anticonvulsant protocol (as per APLS/ patient specific protocol)	Yes No Discuss at time	
8.	IV access	Yes No Discuss at time	
9.	Blood products	Yes No Discuss at time	
10.	Blood tests	Yes No Discuss at time	
11.	Monitoring	Yes No Discuss at time	
12.	Transfer to:	A&E, Ward, Home, Hospice	

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Additional information:

	Name/ service:	Date:
Discussed with Subspecialty Consultant(s):		
Ambulance directive:		

Plan for feeds/fluids:

Where possible we will endeavour to always feed as tolerated but if feeds are not tolerated, we may see some or all of the following: abdominal distension, vomiting, reflux, discomfort. It may therefore be necessary to adjust feeds until tolerated by reducing volume/ concentration/ frequency or rate.

Name: ELCH Hospital Number: NHS Number: DOB:

C. ADDITIONAL PREFERENCES & EXTENDED CONVERSATIONS:

CHILD'S (Personal, religious or cultural):

FAMILY (Personal, religious or cultural) :

PREFERRED PLACE OF CARE/ DEATH:

ORGAN / TISSUE DONATION:

POST MORTEM/ CORONER:

PROCESSES AROUND END OF LIFE: GP visits Confirmation Certification Transfers Bereavement Suites CDOP

Name: ELCH Hospital Number: NHS Number: DOB:

D. WHO HAS AGREED AND SUPPORTED THIS PLAN:

NOTE: THIS IS NOT A LEGALLY BINDING DOCUMENT BUT IT DOES REFLECT THE DISCUSSIONS THAT HAVE TAKEN PLACE REGARDING CARE WISHES IN THE CONTEXT OF A DETERIORATION IN …… HEALTH AND THE WISHES OF HIM/ HER FAMILY OR GUARDIAN.

……OR HIS/HER PARENTS/ GUARDIAN CAN CHANGE THEIR MIND ABOUT ANY OF THE OPTIONS ON THE CARE PLAN AT ANY TIME.

By signing this document, children/ parents/ legal guardian's consent to this document being shared with other professionals (e.g. those listed overleaf)

Only persons with parental responsibility can sign as parent/guardian. This may be social services if a child is subject to a care order.

NAME	SIGNATURE	DESIGNATION	DATE
	I have discussed and support this care plan:	Palliative care consultant	
	I have discussed and support this care plan:	Child/ young person	
	I have discussed and support this care plan:	Parent/ Guardian (1)	
	I have discussed and support this care plan:	Parent/ Guardian (2)	
	I have discussed and support this care plan:	Clinical nurse specialist (PPC)	
	I have witnessed and support this care plan discussion:	Hospice representative	
	I have witnessed and support this care plan discussion:	Social worker	
	I have witnessed and support this care plan discussion:	Other:	
	I have witnessed and support this care plan discussion:	Other:	

PLEASE ENSURE THAT A COPY OF THIS TRAVELS WITH YOUR CHILD AT ALL TIMES. IF YOU ARE GOING TO BE ADMITTED TO HOSPITAL, PLEASE INFORM THE PPC TEAM AND WHEN IN HOSPITAL PLEASE INFORM THE WARD STAFF OF THIS DOCUMENT SO THAT MEDICAL NOTES CAN BE UPDATED ACCORDINGLY.

Name: ELCH Hospital Number: NHS Number: DOB:

E. NAME AND CONTACT DETAILS OF THOSE WITH WHOM THIS FORM IS TO BE SHARED:

	TITLE	NAME & ADDRESS	EMAIL & PHONE
1.	PARENT/ GUARDIAN (1):		Email: Telephone:
2.	PARENT/ GUARDIAN (2):		Email: Telephone:
3.	GP		Email: Telephone:
4.	Children's community nursing team		Email: Telephone:
5.	Community paediatrician		Email: Telephone:
6.	ELCH Consultant (1)		Email: Telephone:
7.	ELCH Consultant (2)		Email: Telephone:
8.	A & E St Thomas's		Email: Telephone:
9.	A & E @ District General Hospital		Email: Telephone:
10.	Local Paediatrician		Email: Telephone:
11.	Hospice		Email: Telephone:
12.	Community palliative care team		Email: Telephone:
13.	School/ Nursery:		Email: Telephone:
14.	Other		Email: Telephone:

For any routine enquiries, please contact the PPC team at ELCH: gst-tr.PPCadmin@nhs.net or PPCadmin@gstt.nhs.uk or on 02071887188 ext 53823.

Name: ELCH Hospital Number: NHS Number: DOB:

EMERGENCY CARE PLAN: Management of Cardio-respiratory Arrest

Regardless of the patient's resuscitation status, the following immediately reversible causes should be treated: choking, anaphylaxis, blocked tracheostomy tube, other (please state):

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

For Full resuscitation → OR	Attempt resuscitation with modifications below: → OR	Do not attempt cardiopulmonary resuscitation DNACPR
Attempt resuscitation as per standard RC (UK) guidelines	Patient-specific modifications to standards resuscitation guidelines AIRWAY: CIRCULATION: DRUGS: OTHER: PICU/HDU	Patient-specific supportive care is documented on pages 2,3 and 4 In event of sudden death 24hour emergency number for doctor who knows the child: ……

Ambulance directive: (e.g transfer to home/ward/Emergency Department/hospice)

……

Reason(s) for decision:

Senior Clinician Name.....Signature.....GMC No.....

Date Initiated .....Date Reviewed.....