Shooting Star Children's Hospices

Name	
NHS No	
Date of completion	

Child and Young Person's Advance Care Plan

Name: (Known as)		**DOB**	
Home address		**NHS number** **Hospital number**	**Allergies**
Home Tel		Mobile Tel	

Specialist Symptom Care Team		
Working hours: 9am-5pm, Monday – Friday		**Out of hours:** 5pm-9am, weekend and BH
Christopher's Shooting Star House Dr AK Anderson (Consultant) Tracie Lewin-Taylor (CNS team leader) Sinead Summers (CNS) Rachael Welsby (CNS)	**01483 230960** **0208 783 2000** Symptom care team members	**P**aediatric **P**atient **A**dvice **by** **T**elephone for **C**are at **H**ome, Hospice and **H**ospital (PATCH) service Tel: **0208 642 6011** (Follow the electronic message, ask for the **operator** then for the **PATCH** service

For Use	Everywhere ☐	Home ☐	School ☐	Hospital ☐	Other Care setting ☐

Date Plan Initiated		Date Review Due	

Key Professionals Involved		
Name	Designation	Contact Details

Date reviewed / amended	**Name & title of lead reviewer**	**Expected review date (if appropriate)**

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

This document is designed to provide a rapid overview of key decisions should an emergency arise when the individual cannot give informed consent for themselves. This is relevant when next of kin / parent(s) are not present immediately

Please ensure a copy of this plan travels with your child at all times

Name	
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Shooting Star Children's Hospices

Contacts

Family tree (diagram)	
Interpreter needed: Y/N	State language needed:
Religion/Cultural beliefs:	

Name and Emergency contact details of person/people with parental responsibility

Other key family members and others (e.g. Siblings, extended family and close friends)		
Name	Relationship/role	Telephone numbers

Who has agreed and supports this plan

Lead Clinician			
Role		**Professional No**	
Signature		**Date**	

Young Person and person / people with parental responsibility		
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 (signatures are optional but help ensure the opinions have been included in decision making)		
Young person (where appropriate – signature optional)		
Name	Signature	Date
Person / people with parental responsibility (signature optional)		
Name	Signature	Date
Name	Signature	Date
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.		

Shooting Star Children's Hospices

Name	
NHS No	
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Decision making process
Medical and care information

Diagnosis
Main Problems and Background information
Social history (include if looked after child)
Communication (needs of child)
Service provision
Community nursing service (eg 7 day service)
Care package
CCG
Hospital (eg open access)
Hospice

Who is involved in decision making? (tick as appropriate)	
☐	Wishes of child / young person with capacity
☐	Wishes of parent(s)or legal guardian for child on 'best interests' basis
☐	Best interests basis (as in Mental Capacity Act 2005) (for 16years and above)
☐	Other / professional (please state)
Comments (e.g emotional detriment to child)	
Clinicians have a duty to act in a patient's best interests at all times.	

Shooting Star Children's Hospices

Name	
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Choices around care

Priorities of care including preferred place for care of child / young person (during management and in end of life (see additional supporting information page 5 to include more detail)
Religious, spiritual and cultural
Other choices of child / young person & family (e.g. friends, siblings, possessions)
Organ & tissue donation(see separate guidance on web link http://www.organdonation.nhs.uk) National contact number: 0300 123 2323 (would post mortem / coroner be required)
Regional contact number (please state):
Psychological Support
Funeral support (e.g. care after death)

This page has been discussed with child / young person / parent / carer:	Professional: (full name and job title)	Date
If page not completed please comment on reasons		

Shooting Star Children's Hospices

Name	
NHS No	
Date of completion	

Additional Information

Shooting Star Children's Hospices

Name	
NHS No	
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Distribution List and Information Sharing

The key worker is responsible for the distribution of the ACP, for bringing it to the attention of professionals, and for circulating any updates to it:	
Name of Keyworker / Symptom Care Member	**Contact Details**
Where multiple hospital specialists are involved in care it is the responsibility of the lead clinician of the setting the child is in at time of death to inform others of the death; please list names and specialities below:	

A full photocopy of the plan to: the child and family will hold a full copy of their plan.
All professionals who receive a copy must be contacted if the CYP dies

		Name and contact details	Date sent
☐	Parents/Guardians		
☐	Local emergency department		
☐	Children's community nursing team		
☐	Hospice		
☐	Lead paediatrician		
☐	General practitioner		
☐	Specialist consultant		
☐	Hospital (ward or assessment unit)		
☐	Respite / short break care provider		
☐	GP out of hours		
☐	Ambulance control		
☐	School / School nurse		
☐	Transition service		
☐	Social services		
☐	Other(e.g. hospital specialists)		
☐	Other(e.g. hospital specialists)		
☐	Other (CDOP, Coroner)		

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Specialist symptom care team contact:
Mon-Fri 9am-6pm:
01483 230960 / 0208 783 2000
Out of hours: Mon-Fri 5pm-9am, Wkend and BH
0208 642 6011
Ask the automated system for the Operator then ask for the PATCH team

Shooting Star Children's Hospices

Acute Deterioration

Management of Cardiopulmonary Arrest (CPR)

*This remains valid even when parents/next of kin cannot be contacted ☐

*Full resuscitation in the event parent is not present ☐

Child's Name	GP
Address	Lead Consultant
NHS No	Local Hospital
DOB	Allergy

Diagnosis/Reason(s) for decision and summary of communication:

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**

In the event of a sudden collapse with respiratory and/or cardiac arrest	
Airway: Positioning and suctioning	**YES/NO**
Breathing: Mouth to Mouth / Bag and Mask Ventilation ………………. minutes	**YES/NO**
Circulation: External Cardiac Compressions	**YES/NO**
Advanced life support: Intubation and Mechanical Ventilation	**YES/NO**
Oxygen Range (please state dose) if available	**YES/NO**
Non Invasive Ventilation (BiPAP, CPAP)	**YES/NO**
Optiflow / Vapotherm (specify)	**YES/NO**
Intravenous / Intraosseous or Access	**YES/NO**
Advanced Life Support with Drugs	**YES/NO**
Other	**YES/NO**
Transfer to Hospital if considered appropriate(other)	**YES/NO**
Additional information (e.g. Intravenous Antibiotics, cannulation attempts)	

Healthcare professional		Witnessed by	
Name		Name	
Professional role		Role/Relationship to child	
GMC/NMC no		GMC/NMC no	
Signature		Signature	
Date		Date	
Review date		Review date	

Shooting Star Children's Hospices

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Gradual Deterioration:

In the event of life threatening deterioration, signs/symptoms to expect (reduced consciousness, colour, altered respiratory effort**:**

Airway Positioning and Suctioning	**YES/NO**
Oxygen Range (if available, please state dose)	**YES/NO**
Non Invasive Ventilation (NIV)	**YES/NO**
Optiflow / Vapotherm (Specify)	**YES/NO**
Oral antibiotic	**YES/NO**
Intravenous antibiotic	**YES/NO**
Intravenous / Intraosseous Access	**YES/NO**
Blood tests (specify)	**YES/NO**
Blood products (specify)	**YES/NO**
Other (e.g. cannulation attempts)	

Transfer to Home / Hospital / Hospice			**YES / NO**
Specific Treatment Plan	**Lead team**	**Date**	**Comments**
Seizure Plan (as per APLS / patient specific protocol)			
Respiratory Plan			
Symptom Care Plan			
Other			

What Access does the child have (e.g. central line / Subcutaneous) (if applicable)
Bleeding (If applicable)
Nutrition and Hydration (e.g. NGT / other) (if applicable)
Organ / Tissue Donation discussed (see page 6 for contact detail) (if applicable)
Other