EVELINA LONDON TRANSFER BEYOND THE ITU 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:	ADDRESS:
PARENT/ LEGAL GUARDIAN (please circle as appropriate & document name): PARENT 1: PARENT 2: FOSTER CARER: OTHER:	TELEPHONE NUMBERS:

PRIMARY DIAGNOSIS/ BACKGROUND SUMMARY:

KEY PROFESSIONALS INVOLVED:

NAME	DESIGNATION	CONTACT DETAILS

Name: ELCH Hospital Number: NHS Number: DOB:

DURING TRANSFER

Who can travel in the ambulance:
Fluids/ Feeds:
IV / CSCI access:
Monitoring:
Ventilation:
Unexpected changes during transfer:

ON ARRIVAL AT DESTINATION

Fluids/ Feeds:
IV / CSCI access:
Monitoring:
Ventilation:
Background medication:
Other medication:
Personal/ memory making:
GP and clinical handover:
Time frames and priorities at the destination:
Other:

Following cessation of ventilation support, we may see:

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

Name: ELCH Hospital Number: NHS Number: DOB:

Plan following withdrawal: Circle **yes** or **no** on all options and complete blanks as appropriate:

		Decision:		Other / Comment:
1.	Comfort and support the child and family…..			
2.	Suction upper airway	Yes	No	
3.	Oxygen (if available)	Yes	No	
4.	Airway positioning manoeuvres	Yes	No	
5.	Insertion of nasopharyngeal/ oral airway	Yes	No	
6.	Mouth to mouth/ Bag and mask ventilation	Yes	No	
7.	Endotracheal intubation and ventilation	Yes	No	
8.	External cardiac compressions	Yes	No	
9.	Advanced life support with drugs and IV or IO access	Yes	No	

PLAN / EXPECTATIONS FOLLOWING CESSATION OF VENTILATION:

__Of note:__ this plan will cover the initial 1 – 2 weeks following a transfer out from the ITU – beyond that a review of the plan will take place.

Name: ELCH Hospital Number: NHS Number: DOB:

A. ADDITIONAL PREFERNCES & 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

B. 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 TRANSFER OUT FROM THE HOSPITAL FOR …………………………AND THE WISHES OF HIS/ 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:	

C. 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:
6.	ELCH Consultant (1)		Email: Telephone:
7.	ELCH Consultant (2)		Email: Telephone:
8.	Local Paediatrician		Email: Telephone:
9.	Hospice		Email: Telephone:
10.	Community palliative care team		Email: Telephone:
11.	School/ Nursery:		Email: Telephone:
12.	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

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 resusitation — OR →	Attempt resuscitation with modifications below: — OR →	Do not attempt cardiopulmonary resuscitation DNACPR
Attempt resuscitation as per standard RC (UK) guidlines	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: ………………………………….

Reason(s) for decision:

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

Date Initiated ....Date Reviewed..