 

**Paediatric Advanced Care Plan- PACP**

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| **Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **HCN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Discussion**\_\_\_\_\_\_\_\_\_**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This care plan has been drawn up following discussion with the child / young person or those with parental reponsibility, and reflects the wishes of the child / young person or parents (where the child cannot express their own wishes) |
| **1.Record of discussion regarding the need for Advanced Care Plan** |
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| **2.Equipment****(use of equipment)**  |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Pulse Oximeter |  |  | Syringe driver |  |  |
| Feeding Pump |  |  | Ventilator |  |  |
| Physio Vest |  |  | Suction Machine |  |  |
| Oxygen |  |  |  |  |  |
| **Other Equipment:**  |
| **Record of discussion** regarding the continued use of equipment |
| **Decisions** |
| **3.Medication** |
| 1. **Review of Medications:** Record of discussion regarding the use of IV / oral antibiotics and other current medications.
2. **Route of administration:** Record of discussion regarding the route of administration of medicationl (*including use of transdermal and subcutaneous routes*)
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| **Decisions** |
| **4.Resuscitation**Parent / child wishes |
| **Resuscitation Plan:** Clinical interventions to be undertaken if \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ were to stop breathing.  |
| **Issue Discussion** | **Decision**  |
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| **Possibilities to be considered**  |  |
| Call 999 and transfer to nearest Hospital with full resuscitation |  |
| Endotracheal tube and ventilation  |  |
| IV / IO access +/- adrenaline  |  |
| PICU and intensive care  |  |
| Airway management including oral / nasopharyngeal airway if it helps |  |
| Rescue breaths and/or bag/mask ventiltation (if heart beat present)  |  |
| Oxygen for comfort (face mask/nasal cannulae)  |  |
| Suction upper airway and other airway clearance techniques |  |
| No active resuscitation beyond comfort and support to the child & family |  |
| Other |  |
| **Record of Discussion regarding Parent/Child/young person’s wishes should a life threatening event happen when parents are not present,** eg attempts to maintain life until parents arrive. Bag and mask, continue for 15-20 mins |  |
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| **5.Family** |
| **Family Wishes for Child:** Record of discussion regarding family and child/young person’s goals and wishes (*including supports / actions required e.g approaching charities*) |
| **Decision:** |
| **Siblings:** Record of discussion regarding the support of siblings, noting key supportive adults and activities (*e.g teacher, relative, friends, sports*)  |
| **Decisions:**  |
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| **6.Preferred Place of Care** |
| **Record of discussion** regarding the preferred place of care in the advanced stage of illness or at end of life. |
| **Decision:**  |
| **7.Spiritual and Cultural Needs** |
| **Record of child/young person and parent’s wishes** around their spiritual and cultural needs during advanced illness and at the time of death (*including cultural and religious priorities*)  |
| **Decision:** |
| **8.Care at time of death and after death** |
| **Record of child/young person and parent’s wishes** regarding care at the time of death *(including cultural and religious priorities)* |
| **Record of parent’s wishes** about the care of their child/young person after death |
| **Any other relevant information: Including wishes for organ donation if appropriate** |
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| **List of Persons to be contacted at time of death** |
| **Name** | **Relationship** | **Contact Number** |
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| **COPIES (Doctor who signs the Emergency Care Plan must forward it to the following professionals )**  |
| Ward □ | Parent [PR]/ Child /Young person □ | GP □ |
| CCN □ | NIAS □ | Emergency Department □ |
| **COPIES CCN or Key worker must forward to**  |
| Respite Unit □ | School □ | NICH □  |
| Others as required □ |  |  |

***Please note this plan can be reviewed/changed at any time following discussion with child/those with parental responsibility***

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| **Signing sheet for Advanced Care Plan****Please sign a new sheet each time plan is changed/updated**  |
| This document has been prepared following discussion with parents and/or child/young person (where relevant). **Yes / No** (please delete) **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **If no please comment:** |
| **Child/Young Person** |
| **Signature** |
|  |
| **Those with Parental Responsibility** |
| Name (print)  |  |  |
| Relationship |  |  |
| Signature |  |  |
| Date |  |  |
| **Professionals**  | **Consultant**  | **Other Professional** |
| Name (print)  |  |  |
| Designation |  |  |
| GMC No |  |  |
| Signature |  |  |
| Date |  |  |
| **Review Date** | **Professional Role** | **Print Name** | **Signature** |
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