 

**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** | | | | | | | | |
|  | | | | | | | | |
| **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*) | | | | | | | | |
| **Decisions** | | | | | | | | |
| **4.Resuscitation**  Parent / child wishes | | | | | | | | |
| **Resuscitation Plan:** Clinical interventions to be undertaken if \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ were to stop breathing. | | | | | | | | |
| **Issue Discussion** | | | | | **Decision** | | | |
| **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 | | | | |  | | | |
| **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:** | | | | | | | | |
| **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** | | | | | | | | |
| |  |  |  | | --- | --- | --- | | **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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