Guy's and St Thomas' NHS
NHS Foundation Trust

EVELINA FAMILY PALLIATIVE CARE PATHWAY

Evelina Children's Hospital

Date care pathway initiated:	
Patient's name:	Known as:
First language:	
Hospital number:	
Date of Birth:	
Home address: Post code:	
Parent/legal guardian:	Relationship: Contact Tel No:

Key People involved:

Key Worker:	Contact Tel No:
Lead Consultant:	Contact Tel No:
Other key people (e.g. family or friends): Name: Name: Name:	 Relationship: Relationship: Relationship:
Primary diagnosis/background summary:	

Date review due:

Date reviewed/amended:	Name & title of lead reviewer	Next review due:

ADVANCED 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: BREATHING: CIRCULATION: DRUGS: OTHER: PICU/HDU:	Patient-specific supportive care is documented on pages 3 and 4 In the event of sudden death 24hour emergency number for doctor who knows the child: .....

Ambulance directive: (eg transfer to home/ward/Emergency Department/hospice)

.....

Reason(s) for decision:

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

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

EMERGENCY CARE PLAN

A. Acute Deterioration

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

Circle **YES** or **NO** on all options and complete blanks as required:

					Comment
1.	Comfort and support the child and family.....				
2.	Suction upper airway	YES		NO	
3.	Face and mask oxygen	YES		NO	
4.	Increase oxygen until comfortable	YES		NO	
5.	Airway positioning/oral/nasopharyngeal airway	YES		NO	
6.	Mouth to mouth/Bag & mask ventilation for.....mins	YES		NO	
7.	Endotracheal intubation and ventilation	YES		NO	
8.	External cardiac compressions	YES		NO	
9.	Advanced life support with drugs & iv access	YES		NO	
10.	Transfer to (e.g.Home/Hospice/A&E).....				

Discussed with PICU : Yes/No* Date: Contact:

Ambulance directive: Yes/No* Date: Contact:

Subspecialty Consultant: Yes/No* Date: Contact:

*Delete as necessary

B. Slow Deterioration

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

*Circle **YES** or **NO** on all options and complete blanks as required:*

					Comment
1.	Comfort and support the child and family.....				
2.	Suction upper airway	YES		NO	
3.	Face mask oxygen	YES		NO	
4.	Increase oxygen until comfortable	YES		NO	
5.	Medication (oral/i.v.)				
	Antibiotics oral / iv	YES		NO	
	Anticonvulsants	YES		NO	
	Other	YES		NO	
	Other	YES		NO	
	Other	YES		NO	
6.	IV access	YES		NO	
7.	Blood products	YES		NO	
8.	Pain relief - oral/subcutaneous/intravenous	YES		NO	
	Physiotherapy	YES		NO	
10.	Monitoring				
	Observations	YES		NO	
	Bloods	YES		NO	
	Other	YES		NO	
11.	Transfer to (e.g. Ward/A&E/PICU/Home/Hospice).....				
12.	Ambulance directive	YES		NO	

Feeding Plan/Fluid Balance:

CHILD & FAMILY WISHES

Date Discussed by:

Child	
Parent	
Professional	

CHILD'S WISHES

FAMILIES WISHES:

OTHER WISHES:

Who has agreed and supports this plan?

The patient or parents can change their mind about any of the options on this care plan at any time.

Lead Consultant - I support this care plan

Name & signature .....Date.....

Child/Young person - I have discussed and support this care plan

Name & signature .....Date.....

Parents/Guardian – We/I have discussed and support this care plan

Name & signature .....Date.....

Other e.g. Nurse Lead (CNS;CCN) - I have discussed and support this care plan

Name & signature .....Date.....

Other e.g. GP - I have discussed and support this care plan

Name & signature .....Date.....

Other e.g. Hospice Doctor - I have discussed and support this care plan

Name & signature .....Date.....

Other people discussed with/informed

1.....

2.....

3.....

NAME & CONTACT DETAILS

Co-ordinator responsible for distributing this pathway:

Name.....Designation.....Contact No.....

√	Copy of this plan is held by	Name	Contact details
	Parent/guardians		
	General Practitioner		
	GP out of hours		
	Paediatrician at ECH		
	ECH/Ward/department		
	PNP at ECH		
	Paediatrician (Community)		
	Hospice Name:		
	Paediatric Community Nurse		
	CNS Specialist Nurse		
	Outreach Nurse e.g. Neonatal		
	A & E Department Name:		
	School-Head teacher		
	Other eg Social Worker		
	Other eg Coroner/Police		