**Insert Child’s name Plan**

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| **RECORD OF INVOLVEMENT** | **Date** | **Completed by** |
| **Universal Child’s Plan**  | Click here to enter text. | Click here to enter text. |
| **Universal Child’s Plan Review**  | Click here to enter text. | Click here to enter text. |
| **Record of a Request for Assistance**  | Click here to enter text. | Click here to enter text. |
| **Child’s Plan**  | Click here to enter text. | Click here to enter text. |
| **Child’s Plan (Other – please specify)** | Click here to enter text. | Click here to enter text. |
| **Child’s Plan Review**  | Click here to enter text. | Click here to enter text. |
| **Child’s Plan (Compulsory Measures)** | Click here to enter text. | Click here to enter text. |

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| **Advocacy offered to child/young person/family** | **Y** [ ]  | **N** [ ]  |

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| **Section A** | Who’s Who? |
| **Section B** | Why do we need a Plan? |
| **Section C** | What does everyone think? |
| **Section D** | Action Plan |
| **Section E** | Chronology |
| **Section F** | Anticipatory Care Plan |

**Anticipatory Care Plan (Section F)**

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| **In the event of deterioration, please follow the agreed interventions below** **(Clearly state wishes around agreed interventions and state those interventions that are identified as inappropriate.)**The Child/Young Person must continue to be assessed and receive appropriate treatment for their health needs and likely reversible causes should excluded. |
| Specify Preferred Place of Care *(support transfer if applicable)*: Click here to enter text. |
| Signs/Symptoms to expect: (*e.g. chest infections, worsening of seizures, deterioration with feeding)* Click here to enter text. |
| Management of episodes of deterioration (*I management of infection, GI deterioration, respiratory deterioration, seizures)*Click here to enter text. |

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| **Wishes around end of life care**  |
| Organ and tissue donation: Click here to enter text. |
| Spiritual and cultural wishes:Click here to enter text. |
| Funeral preferencesClick here to enter text. |
| Other wishes (*ie what is to happen to favourite memorabilia, toys, possessions?)*Click here to enter text. |

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| **Wishes during life** |
| Please use this space to record wishes that are important and specific to the needs of the child/young person and their family during life. Click here to enter text. |

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| **Who knows about this ACP plan?** |
| **Name** | **Contact Details** | **Copy or Notified** |
| Insert copy of ACP into front of medical notes |  |
| ACP Co-ordinator:Click here to enter text. | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| GP:  | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| Scottish Ambulance Service*(Must be sent Copy)* | Base: scotamb.NACCSUPER@nhs.net Tel: Click here to enter text. | Click here to enter text. |
| Lead Consultant:Click here to enter text. | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| Community Paediatrician:Click here to enter text. | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| Acute Paediatricians: *Notification is appropriate* |
| Click here to enter text. | Base:Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
|  | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
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|  | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
|  | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| Community Children’s Nurse:Click here to enter text. | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| District Nurse:Click here to enter text. | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |
| Health Visitor:Click here to enter text. | Base: Click here to enter text.Tel: Click here to enter text. | Click here to enter text. |