**This EHCP contains information to help communication in an emergency for the individual to ensure timely access to the right treatment and specialists.**

**This form does not replace a DNACPR form, advance statement or ADRT**

**Copies of this document cannot be guaranteed to indicate current advice – the original document must be used.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Individual | Mr Template 2 | NHS No | 11122233344455 | **EMERGENCY HEALTH CARE PLAN (EHCP)V15**  |
| Patient Address (inc postcode) | 1 Example PlaceTempletown | DOB | xx/01/1950 |
| Hospital No | xxxxxxxxxxxxx |
| Next of Kin 1 | Mrs Template 2 | Tel no | 22334455 | Relationship | wife |
| Next of Kin 2 | Miss Template 2 | Tel no | 44556677 | Relationship | Daughter |
|  For children and young people, who has parental responsibility? |
| N/A |
|  |  |  |  |
| GP & Practice Details | Dr Jay: The Surgery ; Templetown |
| Lead Nurse | CNS Name | Place of work | TT Community Hosp | Tel no | xxx88776655 |
| Lead Consultant  | Dr Name | Place of work | TT Hospital | Tel no | xxx11335577 |
| **Emergency Out of Hours Person or Service** | Out of Hours Care at Templetown | Tel no | xxxxxxxxxxxx |
| **Other Key Professionals**  |
| DN Name | Place of work | TT Community Hospital | Tel no | xxxxxxxxxx |
| GP Name | Place of work | The Surgery | Tel no | xxxxxxxxxx |
| Dietitian Name | Place of work | TT Hospital | Tel no | xxxxxxxxxx |
| Social worker Name | Place of work | TT Hospital | Tel no | xxxxxxxxxx |
|  |
| For children weight in kg | WEIGHT IN KG  | Date | DD/MM/YYYY |
|  |
| Underlying diagnosis(es) | diagnosis 1 - most troublesome conditiondiagnosis 2 -etc |
|  |
| Key treatments and concerns you need to know about in an emergency | important/essential regular meds - any 'as required' meds in the house? O2? Indications for using these. - any relevant recent treatments, e.g. chemotherapy, surgery |
| Important information for healthcare professionals (if necessary use page 4 for additional information) |
| **If the individual lacks capacity has a MCA best interests meeting made a decision regarding** **treatment? Is there a DNACPR in place?****PAGE 1** |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual | Mr Template 2 | NHS NO: |  11122233344455  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **In the event of:** Anticipated emergency (ies) |  | **What to do:** |  | **EMERGENCY HEALTH CARE PLAN (EHCP)V15**  |
| 1 |  First possible emergency  |  | Partner, relative or parent: How will the individual and closest carers recognise it is happening? Should carers call for urgent help immediately for this emergency? What first aid steps should carers take, e.g. use angina treatments, inhalers, analgesics, have a cup of tea, distraction?For how long should they persist with first aid before asking for professional help? e. If the first aid steps (if appropriate) don’t suffice, who should be called? Name and number, and ‘script’ for caller. Professionals: What actions should the attending healthcare professional take? List these as escalating steps of care. Escalating steps may include early steps to be taken on arrival at hospital, if admission is considered appropriate, or may include recognition of dying and commencement of local protocol for care of dying patients.If a patient requests not to have CPR, or if CPR is agreed to be futile, then a DNACPR form should be completed and kept with the EHCP.Any drugs for use in emergencies must be prescribed on a Community prescription form that is kept with the EHCP. A safe place to store the drugs should be identified and described in the EHCP. |  |
| 2 |  Second possible emergency:  |  | Repeat process as above:Partner , relative , parent instructions and management planProfessionals instructions an management plan using bullet points |  |
|  |  |  | **If a DNACPR decision has been agreed, complete the regional DNACPR document** |  |

**PAGE 2**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual | Mr Template 2 | NHS NO: | 11122233344455 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **In the event of:** |  | **What to do:** |  | **EMERGENCY HEALTH CARE PLAN (EHCP)V15**  |
| 3 | Third possible emergency |  | Repeat process as above:Partner , relative , parent instructions and management planProfessionals instructions an management plan using bullet points |  |
| 4 | EMERGENCY 4 |  | Number the anticipated emergency and link “what to do” information with relevant number Use Bullet points and link “what to do” with relevant groups i.e Carers, District Nurse, Care Home staff etc.  |  |
|  |  |  |  |  |
| Individuals involved in these decisions: |  |
| **CNSName, Dr Jay, Mr Template 2 and Mrs Template 2** |  |
| Background Information about these decisions: |  |
|  | Does the individual have the capacity to make these care decisions? |  |
|  | Has there been a team discussion about treatment for the individual?Has the individual been informed of the decision?Has the individual agreed for the decision to be discussed with the parent, partner or relatives?Has this individual made a verbal or written advance statement? |  |
|  | Has the individual been informed of the decision? |  |
|  | Has the individual agreed for the decision to be discussed with the parent, partner or relatives? |  |
|  | Has this individual made a verbal or written advance statement? |  |
| **For Children** |  |
|  | Have those with parental responsibility been involved in the decision? |  |
| **For those aged 18yrs and over** |  |
|  | Has their Personal Welfare Lasting Power of Attorney, Court Appointee or IMCA been informed of this EHCP? |  |
|  | Has an Advance Decision to Refuse Treatment been written by this individual?**PAGE 3** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual | Mr Template 2 | NHS NO: | 11122233344455 |

|  |  |  |
| --- | --- | --- |
| EHCP Review |  | **EMERGENCY HEALTH CARE PLAN (EHCP)V15**  |
| The EHCP should be reviewed periodically as:* The individual’s condition changes
* The individual’s place of care or circumstances changes
* The patient requests a review
* Ideally, 12 months after the last review
 |  |
| Date review completed | Name and signature of reviewer: |  |
| DD/MM/YYYY | NAME OF REVIEWER | SIGNATURE |  |
| DD/MM/YYYY | NAME OF REVIEWER | SIGNATURE |  |
| DD/MM/YYYY | NAME OF REVIEWER | SIGNATURE |  |
| DD/MM/YYYY | NAME OF REVIEWER | SIGNATURE |  |
| If a new EHCP is written the previous EHCP should be crossed out and marked as ‘invalid’. If there are any doubts about the content of the EHCP there should be a discussion between the individual (if they lack capacity via best interests discussion), parents/carers and the most appropriate senior available clinician at the time of the emergency to ensure that the EHCP still reflects the individual’s best interests and current management plan.If a new EHCP is written the previous EHCP should be crossed out and marked as ‘invalid’. If there are any doubts about the content of the EHCP there should be a discussion between the individual (if they have capacity), parents/carers and the most appropriate senior available clinician at the time of the emergency to ensure that the EHCP sill reflects the individual’s best interests and current management plan. |  |
|  |  |  |  |
| **Discuss / share the information from this EHCP with GP and Key Professionals** |  |
|  |  |  |  |  |
| Responsible Senior Clinician’s signature | CNS Name | Name | CNS Name |  |
| Professional Registration Number | NMC123456 | Date | 14/05/2021 |  |
|  | Status | Clinical Nurse Specialist |  |
|  |  |  |  |  |
| **Additional Information**If required, please use this space to write any additional information that will inform the clinical teamFurther detail about -underlying illness(es) -individual's understanding of illness and possible outcomes - understanding of illness and possible outcomes by the partner, relative or parent - individual's known preferences about place of care and any interventions they would wish to refuse  |  |

**PAGE 4**

**PAGE 4**