**PAGE 1**

**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 | FULL NAME & TITLE | | | | | | | | | | | | NHS No | | | NHS NO | | **EMERGENCY HEALTH CARE PLAN (EHCP)V15** |
| Patient Address  (inc postcode) | ADDRESS | | | | | | | | | | | | DOB | | | DD/MM/YYYY | |
| Hospital No | | | HOSPITAL NO | |
| Next of Kin 1 | NOK 1 | | | | | | Tel no | | TEL NO | | | | Relationship | | | RELATIONSHIP | |
| Next of Kin 2 | NOK 2 | | | | | | Tel no | | TEL NO | | | | Relationship | | | RELATIONSHIP | |
| For children and young people, who has parental responsibility? | | | | | | | | | | | | | | | | | |
| PARENTAL RESPONSIBILITY | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | |  | | | | |  |
| GP & Practice Details | | NAME OF GP, PRACTICE NAME & ADDRESS | | | | | | | | | | | | | | | |
| Lead Nurse | | LEAD NURSE | | | | Place of work | | | | PLACE OF WORK | | | | | Tel no | TEL NO | |
| Lead Consultant | | LEAD CONSULTANT | | | | Place of work | | | | PLACE OF WORK | | | | | Tel no | TEL NO | |
| **Emergency Out of Hours Person or Service** | | | | | | NAME OF PERSON/ SERVICE | | | | | | | | | Tel no | TEL NO | |
| **Other Key Professionals** | | | | | | | | | | | | | | | | | |
| KEY PROFESSIONAL 1 | | | | Place of work | | | | PLACE OF WORK | | | | | | | Tel no | | TEL NO |
| KEY PROFESSIONAL 2 | | | | Place of work | | | | PLACE OF WORK | | | | | | | Tel no | | TEL NO |
| KEY PROFESSIONAL 3 | | | | Place of work | | | | PLACE OF WORK | | | | | | | Tel no | | TEL NO |
| KEY PROFESSIONAL 4 | | | | Place of work | | | | PLACE OF WORK | | | | | | | Tel no | | TEL NO |
|  | | | | | | | | | | | | | | | | | |
| For children weight in kg | | | | | WEIGHT IN KG | | | | | | Date | | | DD/MM/YYYY | | | |
|  | | | | | | | | | | | | | | | | | |
| Underlying diagnosis(es) | | | PRIMARY / RELEVANT DIAGNOSIS | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Key treatments and concerns you need to know about in an emergency | | | (eg. main drugs, oxygen, ventilation, active medical issues, treatment).  Consider agreed treatment in the event of Sepsis and decisions regarding a treatment escalation plan | | | | | | | | | | | | | | |
| Important information for healthcare professionals (if necessary use page 4 for additional information) | | | | | | | | | | | | | | | | | |
| EG: PPC, DNACPR STATUS, CAPACITY ISSUES | | | | | | | | | | | | | | | | | |

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| Name of Individual | FULL NAME & TITLE | NHS NO: | NHS NO |

**PAGE 2**

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| **In the event of:**  Anticipated emergency (ies) | |  | **What to do:** |  | **EMERGENCY HEALTH CARE PLAN (EHCP)V15** |
| 1 | EMERGENCY 1 |  | 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. |  |
| 2 | EMERGENCY 2 |  | 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. |  |
|  |  |  | **If a DNACPR decision has been agreed, complete the regional DNACPR document** |  |

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| Name of Individual | FULL NAME & TITLE | NHS NO: | NHS NO |

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| **In the event of:** | | |  | **What to do:** |  | **EMERGENCY HEALTH CARE PLAN (EHCP)V15** |
| 3 | EMERGENCY 3 | |  | 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. |  |
| 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: | | | | |  |
| Names of professionals / patient / family / carer | | | | |  |
| Background Information about these decisions: | | | | |  |
| Select | | Does the individual have the capacity to make these care decisions? | | |  |
| Select | | 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? | | |  |
| Select | | Has the individual been informed of the decision? | | |  |
| Select | | Has the individual agreed for the decision to be discussed with the parent, partner or relatives? | | |  |
| Select | | Has this individual made a verbal or written advance statement? | | |  |
| **For Children** | | | | |  |
| Select | | Have those with parental responsibility been involved in the decision? | | |  |
| **For those aged 18yrs and over** | | | | |  |
| Select | | Has their Personal Welfare Lasting Power of Attorney, Court Appointee or IMCA been informed of this EHCP? | | |  |
| Select | | Has an Advance Decision to Refuse Treatment been written by this individual? | | |  |

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| --- | --- | --- | --- |
| Name of Individual | FULL NAME & TITLE | NHS NO: | NHS NO |

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| 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 | | SIGNATURE | | | Name | NAME |  |
| Professional Registration Number | | GMC OR NMC | | | Date | DD/MM/YYYY |  |
|  | | | | | Status | STATUS |  |
|  | |  | | |  |  |  |
| **Additional Information**  If required, please use this space to write any additional information that will inform the clinical team  Additional Information | | | | | | |  |

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