



Full Name:.....
 Date of Birth/CHI Number:.....
 Address:.....
 Postcode:.....
 GP Name & Address:.....
 Telephone no:..... Postcode:.....

This **CYPADM** form **must** be used for children/young people before their 16th birthday.
 This **CYPADM** form **could** be used for selected young people after their 16th birthday.

***This Individualised Plan is for use in ALL AREAS
 Home, Hospitals, Emergency Departments, Schools, Ambulance Services,
 Hospices, Respite Care Facilities.***

Children/young people must continue to be assessed, managed and receive treatments that are appropriate for their health and comfort irrespective of their resuscitation status. A more detailed Anticipatory Care Plan may also be in place for some children/young people.

In the event of a sudden collapse or deterioration, the following measures would be appropriate to consider where clinically indicated.

(Clinician completing form must tick actions agreed and score out the actions not required)

**Senior clinician/carer attending should decide whether to call resuscitation back up.
 (2222 in hospital or 999 out of hospital)**

- Attempt full resuscitation
- Mouth to Mouth/ bag & mask ventilation
- Suction upper/oral airway/tracheostomy tube
- Administer O₂ until looks comfortable
- Comfort and support to the child and family
- No active resuscitation**

Additional information:

Responsible Consultant (mandatory):.....

Signature (mandatory):..... Bleep..... DATE:.....

This management plan has been fully discussed and agreed with

Name:..... Relationship:.....

Co Signatures:(optional)

1. Patient/Parent/Witness Signature:..... Date:.....

2. Patient/Parent/Witness Signature:..... Date:.....

Review Date for CYPADM		Responsible Clinician	
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This form should be reviewed as clinically indicated or at least annually.

CHILDREN/YOUNG PEOPLE ACUTE DETERIORATION MANAGEMENT (CYPADM)

Ambulance Crew Instructions

In the event of a **sudden collapse or deterioration** please see the detailed instructions on the other side of this form.

If, whilst in transit, the patient's condition suddenly deteriorates such that death occurs or is imminent, please

Contact (name & telephone no.).....and
take the patient to.....

Thank you for your cooperation in this matter.

Signed (Nurse or Dr):

Name:Date:.....

For patients at home or being discharged to home or hospice

- The original CYPADM Form should go home with the child/young person on discharge.
- The child/young person (if appropriate) and the parents/guardians of the child/young person must be aware of the CYPADM Form and understand its purpose and how it may be helpful in an emergency.
- The appropriate GP/District Nurse (DN)/Out of Hours (OoH) Services/ Children Community Nurse (CCN) must be made aware that a CYPADM Form is in place.
- If school, hospice or respite care facilities are involved in ongoing care then each must also know about the CYPADM Form.
- A copy of the CYPADM Form should be with the child/young person at ALL times.
- Where a CYPADM Form is not with a child/young person everyone should be clearly aware that emergency services will provide a full emergency /resuscitation response if called to attend.

NB: It is essential that the GP, DN and OoH, CCN services are aware of the Children/Young People Acute Management Deterioration Form (CYPADM).

This form should be reviewed as clinically indicated or at least annually.