

Paediatric transition to ACP/MCG

What: The ACP team working alongside the child health service to incorporate ACP and Medical Care Guidance (MCG) into the transition process of patients with a paediatric end-of-life plan, moving from child health to adult health services

Why/rationale: Paediatric patients with chronic and life limiting illnesses undergo a planned transition into the adult health services at ages 15 to 16 years. ACP and MCG provide an established and recognised framework to capture important care wishes (of the patient when competent and of the family and care team for those who permanently lack capacity) so it is available to health care teams involved in their future care in the adult health setting.

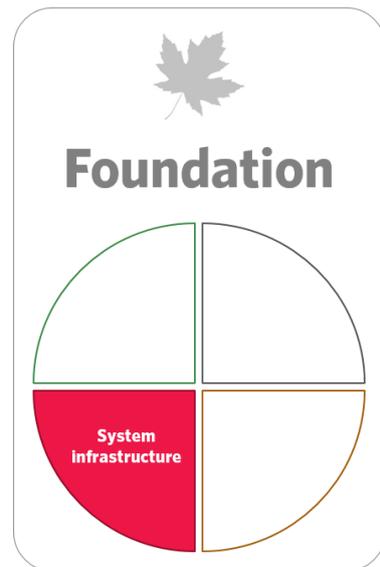
Who: Canterbury DHB

Benefits/value added:

- Provides a consistent and recognised template and process to support a transition in care from the paediatric environment, where staff are familiar with the patient and their care needs/wishes, to an environment where staff may not have met the patient and their whānau before.
- Reinforces an ongoing commitment to previously expressed wishes by converting the paediatric end-of-life care plan into an ACP or MCG (for use after 18-years of age).
- An ACP provides a competent young adult with the opportunity to start expressing their individual care wishes.
- The discussions surrounding an ACP or MCG creation provides an opportunity for preparatory thinking for patient, family and staff, both in terms of the differences ahead of a medical crisis.
- Resuscitation status clearly defined.
- Plans (both new ACPs and MCGs and existing paediatric end-of-life care plans) on Health Connect South (HCS) can be viewed by all users across the South Island.

Risks/challenges:

- The paediatric patients/whānau and staff may not see the value in supporting the creation of an ACP or MCG as part of the transition process.
- For parents, if a young person wishes to and is competent to complete an ACP, they may find some of a young person's values confronting and difficult.
- If the young person is living in residential care, aspects of the ACP/MCG may be at odds with the facility's policy.



Steps: How this looked on the ground

1. Had meetings with leads from the child health team to discuss ways of incorporating:
 - ACP and MCG into the transition process for patients moving from child health services
 - Enduring Power of Attorney/Welfare Guardian options for those who will permanently lack capacity when an adult
 - exploration into the possibility of having Paediatric EOL wishes as part of the Advance Care Plan alert system on HCS.
2. Drafted processes to support child health by:
 - promoting the transition to [ACP](#) and [MCG](#) and providing patients and families with a copy of the relevant HealthInfo webpages
 - facilitating discussions with the child/youth's GP regarding completing a plan, including a letter from the paediatrician to the GP with the expectation that the patient and/or family will be requesting this (as appropriate).
3. Established processes to enable existing paediatric end-of-life plans to be added to HCS/HealthOne, including:
 - designating a child health staff to scan a completed plan on to HCS
 - adding an ACP alert via HOMER/PMS
 - notifying the child or youth's GP
 - keeping any child health statistical log updated.
4. Changed the photograph in HealthInfo MCG information to include an image of a young person at request of a community nurse specialist.

Impact:

- Existing child health end-of-life care plans are now being added to HCS/HealthOne.
- Plans have been identified in ED on patient admissions.

Future opportunities:

- Have an electronic child health end-of-life wishes format available on HCS rather than PDF which may be harder to read.

Things to consider:

- A young person with chronic and life limiting illnesses might use different language and have a different life goals discussion than an older person completing an ACP.