Paediatric Statement of Choices

ADVANCE CARE PLAN

The Paediatric Statement of Choices can be used to record views, wishes and preferences for health care.

Its purpose is to guide or inform those who need to make health care decisions when a child or young person is unable to make those decisions for themselves.

This document is not legally binding and does not provide consent to health care in advance.

www.mycaremychoices.com.au

AUDAX AT FIDELIS
Queensland Government

Paediatric Statement of Choices

The **Paediatric Statement of Choices (Form A / Form B)** is a values-based **advance care planning** (ACP) document that records a child/young person's views, wishes and preferences for their health care into the future, particularly if the child/young person is unwell.

- The content provides guidance to decision makers and health care providers in the event the child/young person is unwell.
- It helps decision makers to consider what decisions the child/young person might have made in the circumstances if they had competence to do so.
- It is not a legally binding document. It does not provide consent to, or refusal of, treatment.

See glossary of terms for more information.

What form should you use?

*Only Form A **OR** Form B should be completed based on current circumstances.*

A	**Form A:** Is used by a young person with decision-making competence.
B	**Form B:** Is used by parents (or guardian/delegated officer) of a child or a young person requiring support with decision-making*.

*Form B should be completed by the child/young person's decision maker(s).This would normally be the child's parents. On some occasions this may be a guardian or a delegated officer from the Department of Child Safety. The child/young person's health care providers should not complete the Paediatric Statement of Choices on the child/young person's behalf.

Recommended steps to complete a Paediatric Statement of Choices

1. **Discuss** health conditions and care options (now and into the future) with the treating team/doctor and where relevant, an Indigenous Health Worker or Hospital Liaison Officer. Consider other cultural support and interpreter if relevant. Discuss values, beliefs and quality of life choices with decision maker(s) and significant others.
2. **Record** views, wishes and preferences for care and contact details of decision maker(s) in Form A or Form B.
3. **Share** copies of the completed document with decision maker(s), family, GP and important others. Also send copies to the Statewide Office of Advance Care Planning (see below).
4. **Review** preferences for care whenever there are important changes in health or life circumstances and update your ACP document(s) accordingly.

What to do with completed ACP documents:

It is important that ACP documents are easily available to authorised clinicians involved in the child/young person's care, if they are needed. The Paediatric Statement of Choices and other related documents can be uploaded to a person's Queensland Health electronic hospital record. Keep the original(s) in a safe place.

Send a **copy / scan** of completed ACP document(s) to the **Statewide Office of Advance Care Planning.**

Email: acp@health.qld.gov.au Fax: 1300 008 227 Post: PO Box 227, Runcorn QLD 4113

You can also upload document(s) to My Health Record. See www.myhealthrecord.gov.au

Advance care planning

If you (or the child/young person) were to have a sudden deterioration or become seriously ill, have you thought about the health care you would want?

What does advance care planning mean?

Advance care planning means thinking now about what health care you would want to have in the future, and communicating your wishes about this. Advance care planning gives you the opportunity to discuss your beliefs and values, and helps you to receive the right care, at the right time, in the right place.

Why plan ahead?

To have your wishes known to help guide the treatment and care received in the future

To let loved ones know what is important if they need to make difficult decisions

To allow decisions about health care to be considered before a crisis occurs

When will your advance care plan be used?

This advance care plan will help guide health care decisions in the future, particularly if you or the child/young person are unwell. Health care providers will still check with the decision maker(s) about this plan.

What if you do not have an advance care plan?

For children and young persons aged under 18 years, parents (or guardian/delegated officer) can exercise authority over decisions about health care that is in the child/young person's best interest.

Aboriginal and **Torres Strait Islander patients** and **families** can contact an Indigenous Health Worker or Indigenous Hospital Liaison Officer for information and support in advance care planning.

Other related documents for children/ young persons that can be used in QLD

For children:

- My Wishes
- Paediatric Acute Resuscitation Plan (PARP)

For young persons:

- Voicing My Choices
- Paediatric Acute Resuscitation Plan (PARP)

Note: The Queensland Advance Health Directive and Enduring Power of Attorney are not applicable to persons under 18 years of age.

Paediatric Palliative Care Service (QLD)

Phone: 1800 249 648
Email: ppcs@health.qld.gov.au

The Paediatric Palliative Care Service provides physical, emotional, spiritual and psychological support to children who have a life-limiting illness. Care focuses on quality of life – it does not mean withdrawing all treatment.

Where relevant, consider other cultural supports. An interpreter service is also available during office hours to provide information and resources about advance care planning in Queensland.

Interpreter

Call 13 14 50

- State the language spoken
- Ask to be connected to the Paediatric Palliative Care Service on **1800 249 648**

GLOSSARY OF TERMS

Advance Health Directive	In Queensland, an Advance Health Directive is a legally binding document that can be used in certain circumstances to provide directions about future health care and to appoint an attorney for health matters. It is a legal document that only applies to persons aged over 18 years with capacity.
Best Interests	Involves weighing the benefits, burdens and risks of treatment, in order to achieve the best possible outcome for the child or young person.
Cardiopulmonary Resuscitation (CPR)	Includes emergency measures to keep the heart pumping (by compressing the chest or using electrical stimulation) and artificial ventilation (mouth-to-mouth or ventilator) when a person's breathing and heart have stopped. It is designed to maintain blood circulation whilst waiting for treatment to possibly start the heart beating again on its own. The success of CPR depends on a person's overall medical condition.
Child / Young Person	A child is defined as a person aged less than 18 years old. A young person is defined as someone aged between 13 and 18 years old. In this document, when the term 'child' is used, it is inclusive of young people.
Competence	A Gillick-competent child has the legal capacity to consent to the provision of medical treatment if they can demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of action. There is no fixed age at which a young person (aged less than 18 years) is automatically capable of consenting to medical treatment generally, or to specific types of medical treatment. Because of the critical nature of decisions around life prolonging treatment, Queensland Health's policy position is that even if the child is Gillick-competent, parents or persons with decision making authority must be involved in all decisions. A medical officer, supported by the health care team, has the responsibility of assessing whether a child is Gillick-competent.
Decision Maker	For a child/young person, a decision maker is someone who has the legal authority to make decisions on behalf of a child/young person. This would normally be the child's parents. On some occasions this may be a guardian or delegated officer from the Department of Child Safety.
Good Medical Practice	Requires the doctor responsible for a person's care to adhere to the accepted medical standards, practices and procedures of the medical profession in Australia. All treatment decisions, including those to withhold or withdraw life-sustaining measures, must be based on reliable clinical evidence and evidence-based practice as well as recognised ethical standards of the medical profession in Australia. Good medical practice requires respecting a person's wishes to the greatest extent possible.
Life-sustaining Measures	Sometimes after injury or a long illness, the main organs of the body no longer work properly without support. If this is permanent, ongoing treatments will be needed to stop a person from dying. These treatments are referred to as life-sustaining measures and can include medical care, procedures or interventions which focus on extending life without necessarily considering quality of life. Certain life-sustaining measures acceptable to one person may not be acceptable to another.
Nurse Practitioner (NP)	A Registered Nurse with the experience, expertise and authority to diagnose and treat people of all ages with a variety of acute or chronic health conditions. NPs have completed additional university study at Master's degree level and are the most senior and independent clinical nurses in our health care system.
Organ or Tissue Donation	For information about organ or tissue donation, visit: www.donatelife.gov.au
Queensland Health electronic medical record	The Queensland Health electronic medical record is a secure digital system which allows health care providers to simultaneously access and update patient information. It is used in place of the traditional paper-based clinical charts.

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Paediatric Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ X

Paediatric Statement of Choices FORM B

A record of values and preferences, for a child or a young person **requiring support** with decision-making

My child's details

The child/young person's details for **whom this form applies:** *(If using a patient label please write "as above")*

Given Names:

Family Name:

Preferred Name: Phone:

Address:

DOB: / / Medicare No:

Gender: ☐ M ☐ F ☐ Other (Please specify):

Details of person completing

Your details, as **the person completing this form:**

Name:

Address:

Phone: Relationship:

I am the decision maker (parent or guardian/delegated officer) for this child/young person: ☐ Yes ☐ No

Other contacts

Name: Phone:

Relationship: This person is also a decision maker: ☐ Yes ☐ No

Name: Phone:

Relationship: This person is also a decision maker: ☐ Yes ☐ No

If there are more than 3 decision makers, please attach details on a separate sheet and tick this box: ☐

PLEASE TURN OVER

DO NOT WRITE IN THIS BINDING MARGIN

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Paediatric Statement of Choices FORM B

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Paediatric Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ X

Name of child/young person **for whom this form applies**:

My understanding of my child's values and considerations

What I would like known about my child: *(e.g. the things that are important to them)*

How and where I would like my child to be cared for:

How I would want my child to be made comfortable:

People I would like to be involved in discussions related to my child's health care:

Spiritual, religious or cultural values that are important to my child which I would like acknowledged and respected:

How I would like my child to be remembered:

Other important information, thoughts or wishes, including care of my child's body after they die, and organ and tissue donation:

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Paediatric Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ X

Name of child/young person **for whom this form applies:**

My child's medical conditions include:

The impact of these conditions has been explained to me: *(tick appropriate box)*

☐ Yes ☐ No *If you have answered 'No' please consult a doctor before continuing this form.*

My child's preferences for medical care and treatment

My child would want these preferences to be considered and respected by doctors and those making health care decisions on their behalf. These preferences are not legally binding and do not provide consent for treatment. If a young/child person does not have decision-making competence, doctors need to speak with the child/young person's decision maker(s) when consent is required for health care.
It is understood that my child will only be offered treatment that is consistent with good medical practice (see glossary).

To my understanding, my child's preference is care that aims to:

If appropriate, consider concepts such as active treatment, management of reversible conditions, quality of life, comfort, dignity, symptom management and treatment.

My understanding of my child's preferences for life sustaining measures

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

If it is consistent with good medical practice:

☐ My child **would wish** CPR attempted **OR**

☐ My child **would NOT wish** CPR attempted **OR**

☐ Other:

Other life-sustaining measures *(tick appropriate box)*

e.g. assisted ventilation (a machine which assists your breathing through a face mask or a breathing tube), artificial nutrition and hydration (a feeding tube through the nose or stomach), kidney machine (dialysis).

If it is consistent with good medical practice:

☐ My child **would wish** for other life-sustaining measures, if it is consistent with good medical practice **OR**

☐ My child **would NOT wish** for other life-sustaining measures **OR**

☐ Other:

My understanding of my child's preferences for other medical treatments

You should talk with the doctor before completing this section.

If considered to be good medical practice,	Would wish for:	Would NOT wish for:	Undecided / no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐

☐ Other:

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Paediatric Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ X

Name of child/young person **for whom this form applies:**

Understanding of the document

By signing below, I/we confirm that this document has been explained to me/us and its purpose is understood.
I/we understand that:

- This form applies to a child/young person where clinical assessment recommends the use of Form B rather than Form A. This includes assessment of competence.
- My child has participated to the greatest extent possible to express their views, wishes and preferences. This document represents my/our best understanding of my child's views, wishes and preferences for health care and may be used as a guide by decision maker(s) and/or doctors in providing appropriate care for my child. It is not legally binding and does not form consent for treatment.
- It may be important to discuss the content of this document with the child/young person's decision maker(s), significant others and their treating doctor(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of the preferences expressed here, my child will continue to be offered all other relevant care, including care to relieve pain and alleviate suffering.
- This document remains current until it is updated or withdrawn, or the child/young person for whom this form applies has been assessed by a registered medical/nurse practitioner as having competence to make their own Form A.

Queensland Health may collect, use or disclose information on this form and will do so in accordance with the National Privacy Principles set out in schedule 4 of the Information Privacy Act 2009 (Qld). For more information see the privacy policy and information sheet available at www.mycaremychoices.com.au

Name(s) of Decision Maker:		
Signature(s) of Decision Maker:		
Date:	/ /	/ /
Relationship to child/young person:		

Please note: Signing by parent or guardian/delegated officer is optional

Usual Doctor/Nurse Practitioner's statement

As a registered medical/nurse practitioner, following an assessment of the child/young person for whom this form applies, I believe that the child/young person currently does not have the competence necessary to complete a Paediatric Statement of Choices Form A. I am satisfied that the person(s) completing this form understands its nature and effect, has made it freely and voluntarily, and is an appropriate person(s) to complete this form.

Name of Doctor/ Nurse Practitioner:

Signature of Doctor/ Nurse Practitioner:

Date: / /

Hospital or Practice Stamp
or
Provider Number

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

Details of other people (if any) involved in the ACP process:

Name:

Phone: Relationship:

IMPORTANT: To allow this document to be available to health care providers, **please send a copy of all four (4) pages of FORM B** to the **Statewide Office of Advance Care Planning**.

Email: **acp@health.qld.gov.au** Fax: 1300 008 227 Post: PO Box 2274, Runcorn QLD 4113