

Pt Initials:

DOB:

Voucher Date:

Today's Date:

# PEDIATRIC PALLIATIVE CARE PROGRAM

## PLAN OF CARE

\*COMPLETE YEARLY AND UPDATE AS NEEDED. SEND COPY TO PPCP NURSE PROGRAM COORDINATOR, JESS BOYEA, VIA SECURE EMAIL OR FAX.

[JESSICA.BOYEA@VERMONT.GOV](mailto:JESSICA.BOYEA@VERMONT.GOV) OR FAX:(802)863-6344

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

INTERDISCIPLINARY TEAM	
PRIMARY CAREGIVER	
PCP	
RN CARE COORDINATOR	
EXPRESSIVE THERAPIST	
COUNSELOR	
CSHN SW	
OTHER	

PPCP Qualifying Diagnosis: \_\_\_\_\_

PATIENT HISTORY	
MEDICAL	<input type="checkbox"/> SEE AGENCY MEDICAL RECORD <input type="checkbox"/> SEE INTAKE & NEEDS ASSESSMENT
SOCIAL/FAMILY	
PSYCHOLOGICAL	
SPIRITUAL/CULTURAL	

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GOALS OF CARE																			
<p>What is the child and family's philosophy of care at this time?</p> <p>*This can and will change over time and therefore should be re-visited annually at minimum or when there is a change in the child's status (improvements or declines in health)</p>	<input type="checkbox"/> Cure oriented <input type="checkbox"/> Avoid Hospitalization <input type="checkbox"/> Quality of life is most important <input type="checkbox"/> No Artificial or life-prolonging measures <input type="checkbox"/> Not assessed/Conversation has not taken place  Comments:																		
DECISION-MAKING/ADVANCE CARE DIRECTIVES																			
<p>Discuss who is the primary decision maker.</p> <p>Does the child have a COLST or advanced care directives?</p> <p>*This can and will change over time. ACD and Resuscitation orders may not be discussed early on in working with a family but should be introduced as early as possible. This is where EOL/funeral planning would be documented, if appropriate.</p>	<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;">Primary Decision Maker:</td> <td></td> </tr> </table> <input type="checkbox"/> COLST on file <input type="checkbox"/> Advanced Care Directives on file <input type="checkbox"/> My Wishes on file <input type="checkbox"/> Voicing My Choices on file <input type="checkbox"/> Education provided <input type="checkbox"/> Not assessed/Conversation has not taken place <input type="checkbox"/> Attempt Resuscitation/CPR/Full Code <input type="checkbox"/> Undecided/No decision made  <input type="checkbox"/> End-of-life or funeral planning initiated  Comments:	Primary Decision Maker:																	
Primary Decision Maker:																			
PAIN AND SYMPTOM MANAGEMENT																			
<p>Include documentation of any scales being used to measure pain or symptoms.</p> <p>*Even stating pertinent negatives is valuable in tracking a child's care over time. The emergency symptom plan can be attached to this document.</p>	<table style="width: 100%;"> <tr> <td><input type="checkbox"/> Fatigue/Activity Intolerance</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Respiratory Symptoms</td> <td><input type="checkbox"/> Anxiety</td> </tr> <tr> <td><input type="checkbox"/> Secretion Control</td> <td><input type="checkbox"/> Depression</td> </tr> <tr> <td><input type="checkbox"/> Nausea</td> <td><input type="checkbox"/> Insomnia</td> </tr> <tr> <td><input type="checkbox"/> Vomiting</td> <td><input type="checkbox"/> Agitation</td> </tr> <tr> <td><input type="checkbox"/> Anorexia</td> <td><input type="checkbox"/> Constipation</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other:</td> </tr> </table> <table border="1" style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 60%;">Pain: Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Location:</td> </tr> <tr> <td colspan="2">Pain Scale Used:</td> </tr> </table>	<input type="checkbox"/> Fatigue/Activity Intolerance	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Respiratory Symptoms	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Secretion Control	<input type="checkbox"/> Depression	<input type="checkbox"/> Nausea	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Agitation	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other:		Pain: Yes <input type="checkbox"/> No <input type="checkbox"/>	Location:	Pain Scale Used:	
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How are these symptoms being addressed?																			
SYMPTOM	INTERVENTION																		

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## GOALS

ACTION ITEM	INTERVENTION	DESIRED GOALS	OUTCOME
<b>Example:</b> ~Healthy Family/Caregiver Coping	~Assess level of anxiety and coping mechanisms ~Establish rapport with family ~Determine level of understanding of diagnosis/prognosis ~Include appropriate family members in discussions around diagnosis/prognosis	~Family will adequately use coping mechanisms to deal with stress ~RN will have regular visits with family and participate in a positive manner ~Family will have realistic understanding and expectations of child	<input type="checkbox"/> Achieved Date:  <input type="checkbox"/> Ongoing Date:  <input type="checkbox"/> Unsuccessful Date:
<b>Example:</b> ~Child will have decreased fatigue and increased activity tolerance	~Recommend schedules and adjust activities as necessary ~Teach family energy conservation techniques and allow for frequent rest. ~Track symptoms that may interfere with activity or sleep	~Identify negative factors affecting performance and reduce their effects, if possible. ~Lifestyle will be adjusted to energy level ~Child's symptoms will be adequately managed to encourage activity	<input type="checkbox"/> Achieved Date:  <input type="checkbox"/> Ongoing Date:  <input type="checkbox"/> Unsuccessful Date:
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NOTES

**PPCP CARE COORDINATOR:**

**SIGNATURE:**

**DATE:**

**IF NO CHANGES NECESSARY AT YEARLY REVIEW, DATE AND INITIALS:**