KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

# SPECIAL CARE PLAN: CHILD / NEWBORN

*This document is to be used for a child with a poor /guarded prognosis where clarification is necessary for management options on current and future care.*

***PLEASE ENSURE A COPY OF THIS DOCUMENT IS AVAILABLE IN THE PATIENTS MEDICAL NOTES, A COPY IS GIVEN TO THE FAMILY, THE PRIMARY PHYSICIAN AND RELEVANT MEMBERS OF THE MULTIDISCIPLINARY TEAM***

| NAME: | IP N°: |
|---|---|

## SPECIAL CARE PLAN STEPS

| DATE | TIME | STEP | SIGNATURE |
|---|---|---|---|
| | | 1. Review condition, considering all therapeutic options and potential outcomes | |
| | | 2. Discuss options, outcomes and appropriate goal with caregiver | |
| | | 3. Devise the best possible care plan with caregiver | |
| | | 4. Provide bereavement counselling and support | |
| | | 5. Record participants in devising the care plan (below) | |
| | | 6. Record special care plan (overleaf) | |

## REASONS FOR SPECIAL CARE PLAN

| REASON | KEY DETERMINANT | ✓ | UNDERLYING ILLNESS |
|---|---|---|---|
| **I. Life is limited in quantity** | 1. Brain stem death | | |
| | 2.Imminent death with physiological deterioration despite treatment | | |
| | 3. Inevitable death with no beneficial interventions | | |
| **II. Life is limited in quality** | 1. Burden of treatment outweighs potential benefits | | |
| | 2. Burden of the child's underlying condition causes suffering that overcomes potential benefits | | |
| | 3. Lack of ability to benefit | | |
| **III. Informed competent refusal of treatment** | | | |

## SPECIAL CARE PLAN PARTICIPANTS

| | NAME/DEPARTMENT | CONTACT DETAIL |
|---|---|---|
| Family member/Caregiver | | |
| Family member/Caregiver | | |
| Doctor | | |
| Doctor | | |
| Nurse | | |
| Therapist | | |
| Social worker | | |
| Psychologist | | |
| Other (specify) | | |

## DETAILS OF DISCUSSION WITH TEAM AND FAMILY/CAREGIVER (RATIONALE FOR SPECIAL CARE PLAN)

| | |
|---|---|
| **CURRENT CONDITION** | |
| | |
| | |
| | |
| **PROGNOSIS** | |
| | |
| | |
| | |

Name…… Hospital number…… Page number……

| | |
|---|---|
| **GOALS OF CARE & POSSIBLE MANAGEMENT** | |
| | |
| | |
| | |
| **FAMILY QUESTIONS & CONCERNS** | |
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| | |
| | |

| | | | |
|---|---|---|---|
| Pastoral / Spiritual support offered | | Family (& Sibling) support & visits facilitated | |
| Referred to Psychologist | | Referred to social Worker | |
| Memory box (Hand & Foot prints) | | | |

| **INTERVENTION** | **INITIATED:** | | **REVIEWED:** | |
|---|---|---|---|---|
| **Date & Time** | | | | |
| **Authorized by:** | **Print** | **Sign** | **Print** | **Sign** |
| Doctor 1 | | | | |
| Doctor 2 | | | | |
| Registered nurse | | | | |

| **Cardiopulmonary resuscitation** | **Y/N** | **Details** | **Y/N** | **Details** |
|---|---|---|---|---|
| Stimulation | | | | |
| Airway management | | | | |
| Bag-valve-mask | | | | |
| Nasal CPAP | | | | |
| Ventilation | | | | |
| Cardiac massage | | | | |
| Drugs/cardioversion | | | | |
| **Further care** | **Y/N** | **Reason** | **Y/N** | **Reason** |
| Incubator | | | | |
| ICU admission | | | | |
| Oxygen | | | | |
| IV fluids | | | | |
| TPN | | | | |
| Feeds | | | | |
| Inotropic support | | | | |
| Blood products | | | | |
| Antibiotics | | | | |
| Blood tests | | | | |
| Pain control/comfort | | | | |

| **SPECIAL CARE PLAN RESCINDED** | | | | |
|---|---|---|---|---|
| Reason | | | | |
| | | | | |
| **RESCINDED BY** | **NAME** | **SIGNATURE** | **DATE** | **TIME** |
| Doctor 2 | | | | |
| Doctor 1 | | | | |
| Registered nurse | | | | |