



NICU COMFORT CARE PLAN



Privileged Visitors: _____
 Social Support System: _____
 Siblings _____

Social Worker: _____
 Psychologist: _____
 Translator: _____
 Spiritual Care: _____



Visit/Call Log: YES / NO _____ DYP involved: YES / NO _____

Languages: _____

NEXT MEETING

Last Meeting: _____
 Goals: _____

 Date: _____ Location: _____
 Participants: _____

EMOTIONAL COPING

MOTHER	FATHER
Feelings Expressed:	Feelings Expressed:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Date: _____	Date: _____

SPIRITUAL BELIEFS

Religions: _____
 Meaningful Rituals and Practices: _____

PRESENT CONCERNS

Date: _____

PARENT'S REQUEST FOR END OF LIFE

COMMUNICATION TIPS

Ask simple, open ended questions, be patient, wait for responses, allow for silence, sit together for longer conversations. Involve family in care. Validate their role as parents.

- ◇ What is your priority for baby today?
- ◇ What is worrying you the most? Are you able to sleep?
- ◇ Are there any thoughts that give you comfort?
- ◇ Have you been able to talk to anyone (friends/family/ etc) about what is going on with baby?

Avoid platitudes: "I understand how you feel" "time heals" "be strong" "baby will be in a better place"

PARENT EMPOWERMENT

Empower parents to participate in care as much as possible.
 List acquired skills and topics for further teaching.

Skills (ex: bath, feed, pump, touch, temp, PO/NG meds, eye care, GT care)

Teaching topics: _____

Lactation consultation re- milk suppression/donation

NOTES



NICU COMFORT CARE PLAN



Name _____

Mother: _____
Father: _____
Other: _____



Primary RNs: _____

Primary MD: _____

Consultants: _____



RESUS MEASURES

DATE: _____

D x S x DATE

DOB _____ Bwt: _____ g

PARAMETERS

RESPIRATORY

VENTILATORY PARAMETERS

iNO: _____
Baseline FiO₂: _____
SpO₂ targets: _____
Chest Physio: Q _____
Suctioning: Q _____

CHEST TUBES

Rt Lt _____

Sutured @

Inserted

Removed

TRACHEOSTOMY

Trach Size: _____
Next Trach Δ: _____

RT NOTES

CARDIOVASCULAR

Vitals Q: _____ BP Q: _____

Pulses Q: _____

VASCULAR ACCESS

PICC / CVL: _____ lumen

Fr: _____ Ext. portion: _____

Inserted: _____

Removed: _____

Drsg Δ due: _____

Insuflon: _____

UVL UAL

Sutured @

Inserted

Removed

ELIMINATION

Strict In/Out: Yes / No

Foley Inserted: _____

Ostomy notes: _____

NEURO / PAIN

Pain/Sedation Scale Q: _____

Type: _____

Goals: _____

Neuro Vitals Q: _____

GASTRO-INTESTINAL

WtQ: _____ LtQ: _____

HCO: _____ AbdoGirth Q: _____

Milk Type: _____

Route: _____

Frequency: _____

Duration: _____

- NG - NJ - OG - OJ -

Inserted: _____

Secured @: _____

GT - GJ Size: _____

Inserted: _____

Balloon check:

Q: _____ ml: _____

FLUIDS

TFI: _____ Weight: _____

SYMPTOM MANAGEMENT

HYGIENE

Bath Q1-2 D Last: _____ Next: _____

Mouth care Q: _____ Chlorhex: Yes / No

PHYSIO

Δ Position Q2-6h (max) Q: _____

Favorites: _____ Avoid: _____

ROUTINE

DRSGs

PAIN

MED: _____ Non-pharmacological measures: _____

MED: _____

MED: _____

SYMPTOMS INTERVENTIONS (pharmacological & non-pharmacological)

RESP / CARDIO / GI
NEURO / OTHER

Updated by: _____

Date: _____