**

Cystic fibrosis Care Plan

for education and care

****

|  |  |
| --- | --- |
|  |  |
| To be completed by the treating health professional and parent or legal guardian.This information is confidential and will be available only to relevant staff and emergency medical personnel. |
| Name of child/young person: |  |
| DOB: |  | Review date: |  |
| Allergies: |  |
| Education or care service: |  |  |

|  |  |
| --- | --- |
| **DESCRIPTION OF CONDITION**Detail issues relevant to education and care | **RECOMMENDED CARE**Describe recommended care |

|  |
| --- |
| **Overall wellness** |
| [ ]  | Fluctuations in wellness/hospitalisation  |       |
| [ ]  | Cough management  |       |
| [ ]  | Management of port(s)  |       |
| [ ]  | Management of intravenous (IV) line  |       |
| [ ]  | Mental health issues  |       |
| Provide explicit advice about contact controls between the child or young person and others with cystic fibrosis *(ie need to use standard precautions, socialisation issues)* |       |

|  |
| --- |
| **Diet** |
| [ ]  | Special dietary requirements  |       |
| [ ]  | Gastronomy buttons (night feeds)  |       |
| [ ]  | Enzyme supplements ie Creon *(medication agreement* ***not*** *required)*  |       |
| [ ]  | Support with management of enzymes  |       |
| [ ]  | Other *(specify ie need to encourage eating)*  |       |

|  |
| --- |
| **Therapy and care** |
| [ ]  | Nursing and physiotherapy  |       |
| [ ]  | Nebuliser treatments  |       |
| [ ]  | Home based care  |       |
| [ ]  | Other *(specify ie timing of therapy, equipment and facility issues)* |       |

|  |
| --- |
| **Body temperature control** |
| All children and young people with cystic fibrosis need to avoid temperature extremes |
| [ ]  | Clothing  |       |
| [ ]  | Environmental management |       |
| [ ]  | Salt tablets or powder *(medication agreement* ***required****)*  |       |
| [ ]  | Other       |       |
| [ ]  | Provide detail of any special measures required *(ie air conditioning or clothing requirements, avoidance of exposure to direct sun light)* |       |

|  |
| --- |
| **Curriculum or workplace participation**  |
| A curriculum plan should be developed to minimise disruption to the child or young person’s learning |
| [ ]  | Tiredness |       |
| [ ]  | Shortness of breath |       |
| [ ]  | Difficulty concentrating  |       |
| [ ]  | Fluctuating capabilities *(ie pre or post hospitalisation)*  |       |
| [ ]  | Need for frequent, self-monitored physical activity |       |
| [ ]  | Need to plan for episodic absence |       |

|  |
| --- |
| **Potential emergency situation** |
| **OBSERVABLE SIGN** |  **ACTION OR FIRST AID RESPONSE** |
|  |  |
|  | Change in cough | **⇨** | **⇨** |       |  |
|  |  |
|  | Damage to port or gastrostomy button | **⇨** | **⇨** |       |  |
|  |  |
|  | Sore / red / bleeding / oozing port | **⇨** | **⇨** |       |  |
|  |  |
|  | High temperature | **⇨** | **⇨** |       |  |
|  |  |
|  | Shortness of breath | **⇨** | **⇨** |       |  |
|  |  |
|  | Dehydration eg salt crystals visible on skin | **⇨** | **⇨** |       |  |
|  |  |
|  | Reported discomfort | **⇨** | **⇨** |       |  |
|  |  |

|  |  |
| --- | --- |
| **AUTHORISATION AND AGREEMENT***(To be signed after form has been completed)* | The following settings have been considered in the development of the health care plan and is appropriate for use in the following: |
| [ ]  | Children’s centre, preschool or school | [ ]  | Childcare, Out of School Hours Care |
| [ ]  | Camps, excursions, special event, transport (incl. aquatics) | [ ]  | Work experience or other education placement |
| [ ]  | Respite, accommodation | [ ]  | Work |
| [ ]  | Transport  | [ ]  | Other (specify)       |
| *Treating health professional* |
|  *(print name & practice/hospital or stamp)*           | Professional role  |       |
| Email or signature  |       |
| Telephone       | Date |       |
| *Parent or legal guardian; or adult student*  |
| * **I understand and agree with the health care plan as indicated above**
* **I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).**
* **I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care.**
 |
| (name)      | (relationship)      |
| (email or signature)       | (date)      |