Formal Assignment: Nursing Care Plan

This is one of the 2 formal assignments used during the paediatrics rotation. Students complete one of these assignments based on their clinical experience in the hospital. They have one patient (and family) to care for, and in this assignment which is based on the Orem model of Nursing, they need to find out background information about the child and family (Basic Conditioning Factors), as well as medical information, and they need to organise a plan of care based on the child’s developmental level. A major focus of the paediatrics rotation is to understand growth and development in children from infancy through adolescence. They must think about what the developmental needs are in their patient in relation to their illness and hospitalisation, and created a plan of care that aims at meeting these needs. The plan is based on the Nursing Process which is the universal process applied when organising nursing care. It is composed of 4 steps: Assessment, Planning, Intervention and Evaluation.

BASIC CONDITIONING FACTORS (allow space as appropriate to complete correctly and thoroughly)

1. Age ___________
2. Sex ___________

3. Developmental stage: _____________________________________
   a. cognitive:
   
   b. physical:
   
   c. psychosocial:
      i. Identify Erikson’s principal conflict for your patient.
      ii. Provide data that illustrate this developmental stage in your patient.

4. Health state
   a. Current state of well being:
      • Physical:
• Emotional:

b. Parent/family description of:

i. The effects of condition/illness on their way of life

ii. Their understanding of health and treatment for their child

iii. Their involvement in /attitude towards treatment

iv. Their health goals and services expected.

5. Health Care System Factors:

a. Current medical diagnoses:

b. Admission date:

c. Summary of current medical condition:

d. Medical plan of care and treatment / surgery and date of surgery:

e. Medical orders for this admission:

f. Consultations or referrals specifying plan of care and treatment by other professionals:
6. **Socio-cultural Orientation**
   a. Languages: Spoken &/or understood by family

   b. Religious and/or cultural factors to be considered during hospitalisation or in discharge plans

   c. Level of education or parents' occupation: (as applicable)

7. **Family System Factors**
   a. Genogram with a complete legend *(Please take the space necessary)*

   b. Significant others:

   c. Principle concerns of the family:

8. **Patterns of Living:**
   a. Present and/or past occupation(s) of child & family:
      
      Demands of work or daily life:

   c. Resources:
      Economic:
      
      Social/community:
      
      Medical/health:
      
      Time available for self-care:

   d. Life experiences (past medical history; previous illness; hospitalisations)

   d. Family &/or Individual Coping methods:
DEVELOPMENTAL NURSING CARE PLAN

Child’s Initials: _______ Child’s age and developmental stage: _______________________________________________________

REQUISITES: (DSCR)

<table>
<thead>
<tr>
<th>PERTINENT DSCR DATA</th>
<th>DATA ANALYSIS WITH CONCLUSION... (THE SO WHAT QUESTION?)</th>
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<tr>
<td>PERTINENT BCF DATA</td>
<td>DATA ANALYSIS</td>
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**NURSING CARE PLAN: DIAGNOSIS & PRESCRIPTION**

<table>
<thead>
<tr>
<th>ACTION DEMAND</th>
<th>SELF-CARE AGENCY (assess patient’s ability to perform each of the general methods. Place a * beside any power component in which patient has limitations to perform any of the general methods. Please note these may apply to the Parents when the child is very young.)</th>
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<tbody>
<tr>
<td>Particularized self-care requisite:</td>
<td>1. Attention span for each of the gms</td>
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<td>2. Physical energy for each of the gms</td>
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<td>General methods (gms)</td>
<td>3. Control of the body position for each of the gms</td>
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<td>4. Ability to reason for each of the gms</td>
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<td>5. Motivation for each of the gms</td>
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## NURSING CARE PLAN: DIAGNOSIS & PRESCRIPTION

<table>
<thead>
<tr>
<th>SELF-CARE AGENCY (assess patient’s ability to perform <strong>each</strong> of the general methods)</th>
<th>SELF-CARE DEFICIT</th>
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<tr>
<td>6. Ability to make best decisions regarding each of the gms</td>
<td>SCD STATEMENT:</td>
</tr>
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<td>7. Has the required knowledge or has the ability to acquire knowledge regarding gms</td>
<td>NURSE WILL AFFECT SCA OR AD?</td>
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<td>8. Repertoire of skill to be able to perform gms (cognitive, perceptual, manipulative, Communication &amp; interpersonal)</td>
<td>NURSING SYSTEM TO BE USED:</td>
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<td>9. Ability to adjust self-care priorities to include gms</td>
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<td>10. Consistently performs gms integrating into his/her life</td>
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</tbody>
</table>
**GOAL & EXPECTED OUTCOME** | **NURSING ORDERS AND METHODS OF HELPING AND PATIENT ACTIONS** | **SCIENTIFIC RATIONALE**
---|---|---
GOAL: |  |  
EXPECTED OUTCOME: |  |  

*312 winter 2010*
NURSING CARE PLAN: EVALUATION

EVALUATION/MANAGEMENT

Was the plan implemented? If so describe how this was done, or how you would have done this if you had had the opportunity.

What if any arrangements were made for your plan to be implemented & followed up?

Describe some additional or alternative plans in optimising care for your patient.
Please provide separate reference page as per APA