Section 1

Principles of Care Planning
The Nature of Care Planning and Nursing Delivery for Infants, Children and Young People

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(contribution from Lisa Hughes)

Introduction

As a healthcare professional caring for children, young people and their families we are accountable for our individual practice. Therefore we must strive to deliver high quality care, acknowledging evidence-based practice and recognising finite resources within contemporary healthcare systems. In order to achieve success, care planning and delivery of individualised care must encompass multiprofessional collaboration, involving service users and carers as essential contributors to the overall process.

Within this introductory chapter the children’s nurse will be provided with an overview of the nursing process, its components and how these assist in organising and prioritising care delivery to the child and family. Philosophical perspectives of care will also be discussed and how this impacts on care delivery in the clinical setting. In conjunction with these aspects of care planning, several models of nursing will be explored, and their contribution in the planning and delivery of care will be illustrated within the scenarios in the second section of this book.

Nursing process – what is the nursing process?

The nursing process is a logical, structured approach, which promotes the nurse’s critical thinking in a dynamic manner. This process is used to identify and deliver individualised family-centred care, supported by nursing models and philosophies. Yura and Walsh (1978) identified this process, consisting of four interrelated stages (see Figure 1.1):
More recently, Castledine (2011) has acknowledged the evolvement of the nursing process to be a methodical way of thinking that guides care delivery; whilst focusing on the patient the nurse should base best practice on available evidence with artistic interpretation. More recently, however, this process has sometimes included a fifth stage relating to ‘nursing diagnosis’. For example, a six-week-old infant has been brought to the hospital with a history of breathlessness and poor colour, especially during feeds, who tires easily and poor weight gain has been noted. Upon examination, heart rate and respiratory rate are both increased and this may lead the nurse to consider a possible cardiac related diagnosis. In utilising the nursing process a problem-solving approach is applied to the management of individualised patient care. The application of the process is continuous and cyclical in nature and commences with the assessment stage.

Assessment

This important stage of the care planning process aims to collect and record information pertaining to the health status of the individual child and its effect on the family unit. This phase of the nursing process should provide a comprehensive insight into the needs of the child and their impact on the integrity of the family. The children’s nurse must consider not only the physical needs of the child but address the social, emotional and spiritual needs of the child and entire family. In order to achieve a comprehensive assessment the children’s nurse must utilise a range of proficiencies, including theoretical knowledge and interpersonal skills. Matousova-Done and Gates (2006) highlight the need to both observe and listen to the child and family, utilising verbal and non-verbal communication with the use of appropriate questioning skills to ensure an accurate nursing assessment.

A precise and comprehensive assessment is vital to identify the problems which are currently encroaching on the child’s health status and ultimately will ensure safe, effective
and efficient nursing care for the child. This stage of the process links closely with the
discrete fifth stage identified earlier as nursing diagnosis, which is supported by an accurate
and comprehensive assessment of the child’s health needs. During the assessment stage
the children’s nurse is also involved in analysing and interpreting the information collected,
thus contributing to the formulation of a care plan.

A very good example of assessment is the ABCDE (airway, breathing, circulation, disabil-
ity, exposure) systematic approach to assessing the acutely ill child, as recommended by
Dieckmann et al. (2000) and the Resuscitation Council UK (2005). This approach aims to
enable healthcare staff to recognise when they need additional support from the interprofes-
sional team (see Chapter 8). Furthermore, this systematic process helps guide the healthcare
professional in planning the frequency of ongoing assessment, especially in the paediatric
intensive care setting (see Chapter 16).

Planning

During the essential second stage of the process, a plan of care is developed aimed at
addressing the problems identified in the assessment phase. This phase of the process
involves cognitive and written elements in identifying goals to meet the child’s needs. The
children’s nurse develops mutually agreed goals which endeavour to address the child’s
problems through the provision of nursing care. These goals are then further developed
within the plan, in a sequence of interventions aimed at resolving, controlling or preventing
escalation of the problem. In creating these goals, Wright (2005) proposes they should be
SMART: specific, measurable, achievable/agreed, realistic and time-limited. The care plan
is developed to guide the nursing interventions in a timely manner to meet the needs of
the child and family.

The children’s nurse must be able to clearly articulate and document priorities of care,
tailored to meeting the individual needs of the child and family, and easily understood by
all members of the interdisciplinary team.

Effective communication with the child and family are integral to this stage of the
nursing process, as the children’s nurse must work collaboratively to ensure the care plan is
dynamic in meeting the needs of the child and family. In developing the care plan the
children’s nurse must engage in developing a partnership with the child and family in which
they are active partners in the decision-making processes and their involvement in care
provision is recognised. This partnership requires empowerment and negotiated involve-
ment of the child and family, which requires skilled children’s nurses who are able to ensure
children and their families are at the centre of effective care planning (Corlett & Twycross
2006). Having identified, agreed and set short and long-term goals specific to the child’s
needs, these must be regularly evaluated during implementation to ensure they remain
responsive to the individual’s requirements.

Implementation

This penultimate stage of the nursing process relates to the delivery of care, which has
been planned based on the needs of the child and family. Nursing interventions should aim
to achieve the goals identified in the care plan and these should clearly identify the actions
to be undertaken by the children’s nurse. The children’s nurse must possess the knowledge,
skills and abilities to deliver the care to the child and assess the appropriateness of planned
interventions (Alfaro-LeFevre 2006). Effective communication with the child and family is
central to the success of implementing the care plan, which may require adjustment in response to changing needs.

The cooperation and involvement of the child and family is a pre-requisite in this phase of the nursing process. Children and their families must be given choices and involved in decisions regarding nursing interventions, and their participation will personalise their own care implementation. All goals set must be clear and agreed by the child, family and other carers, including health professionals. Identifiable goals should be achievable, within a realistic timeframe for those involved in care delivery, whilst recognising their continued appropriateness for the child.

**Evaluation**

The fourth and final stage of the nursing process, requires the children’s nurse to consider the impact of the preceding three stages on the child’s care trajectory. However, it is essential that the children’s nurse continually evaluates the child’s response to interventions and modifies planned care to meet the individual’s needs and their response to previously identified goals. Overall, this evaluation process aims to recognise changes in the child’s condition and identify the need for modification. Analysis of the care delivered by the children’s nurse requires critical thinking in order to consider its effectiveness and other possible required interventions to meet the changing needs of the child. The frequency of evaluation may vary depending on the acuity of the child’s condition.

This evaluative stage of the nursing process links closely with the assessment phase of the cycle, assessing the attainment of previously identified priorities of care and goals (Heath 2005). Documentation and reporting in this phase of the nursing process is critical in accurately measuring and recording the child’s response to planned interventions and to support the continuity of care delivery. Furthermore, this assists in information sharing between healthcare professionals and identification of progress towards goal attainment and also the continued relevance of previously identified goals.

**Nursing diagnoses**

The North American Nursing Diagnosis Association (NANDA International) is the clearing house for nursing diagnosis work both within the United States of America and internationally (Carpenito-Moyet 2010). This association was initially established in 1973, and later recognised worldwide as NANDA-I in 1982 and is committed to developing the nursing contribution to patient care through ‘nursing diagnoses’ which informs the creation of care plans (NANDA International 2008). Those care plans approved by NANDA International are rigorously tested and refined in line with current best practice and evidence-based guidelines in clinical settings. Within the NANDA International system, five levels of nursing diagnoses are identified:

- Actual
- Risk
- Possible
- Syndrome
- Wellness
**What is a nursing diagnosis?**

This is a professional judgement relating to the health problems of the individual or family, which is used to identify appropriate goals and interventions in nursing plans of care, based on a holistic nursing assessment (see Chapter 34).

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**Nursing Process in Practice**

Overall, this nursing process provides a flexible framework to organise and deliver care of a high standard to the child and family in a holistic manner (NMC 2008). This facilitates recognition of the individual’s contribution, their consent to care, whilst acknowledging organisational quality initiatives, such as policies, procedures and clinical audit (Holland et al. 2008). This nursing process framework assists the children’s nurse in documenting care assessment, planning, implementation and evaluation, whilst recognising the legal responsibility and professional accountability aspects of accurate record keeping.

In order to apply the nursing process, the children’s nurse requires knowledge, skills and attributes which will only develop over time with practice and experience. Therefore, the nursing student will initially require direct supervision and mentor support (see Chapter 9) in applying the nursing process to their clinical practice, ensuring care planning and delivery is safe, competent and effective in meeting the child and family’s needs (NMC 2010).

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**Planning of care – what is a care plan?**

A care plan is a comprehensive record (handwritten, pre-printed or electronic) of essential information which is created following discussions between the child, family and the children’s nurse, detailing priorities of care aimed at meeting the individual’s needs. This record consists of a table featuring problem identification, patient goals and nursing intervention, alongside day-to-day living activities affected (see Appendix 1). This is a legal document which is managed and stored in accordance with legislative and professional guidelines, whilst still being accessible to the individual patient and other healthcare professionals with responsibility for care delivery, whether in the hospital or community setting (NMC 2009).

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**Activity 1.1**

Look at these practice-based questions.

1. Identify which care planning documentation is currently being used in your clinical placement:
   - (a) Hospital
   - (b) Community

2. Discuss with your clinical mentor which nursing model is being utilised to support care delivery:
   - (a) Has the model been adapted for children’s nursing?
   - (b) How does the model ensure individualised care of the child and family?
In addition to the framework provided by the nursing process, care plans are normally developed with the support of a nursing model, which assists in managing and enhancing effective, high quality care delivery. The development of nursing models attempts to link nursing theory to clinical practice and indirectly informs the growing body of nursing knowledge. Various models of nursing are available and utilised, for example Roper, Logan and Tierney (1985), Casey (1988; 1995), Mead [McClune & Franklin 1987], Orem (1995) and Neuman’s system model [Neuman & Fawcett 2002], as well as chapters within this book that demonstrate the application of these models to clinical practice. These models are flexible structures that can be easily adapted to incorporate elements from other models in order to address individual care needs, encouraging the children’s nurse to think creatively about the holistic care of the infant, child or young person and their family.

Increasingly, evidence-based practice is advocated globally as effectively delivering quality care, and thus must be integrated within care plans for the individual (Parsley & Corrigan 1999). The children’s nurse must be able to appraise nursing research critically and use this up-to-date knowledge to underpin their clinical judgement and practice, and promote efficiency within healthcare systems. Whilst aiming to provide contemporary high quality care, the children’s nurse should reflect upon his/her knowledge and experiential learning, which are key requisites to ensuring best practice as identified in professional regulatory guidelines [NMC 2008].

The nursing care plan is also supportive of engaging and sustaining interdisciplinary collaboration with the child, family and other health professionals involved in their care. Children’s nurses do not work in isolation, instead care delivery is organised around a team approach and in collaboration with other members of the multiprofessional team. More recently, integrated care pathways have evolved, supporting the development of a multiprofessional document, to which the nursing care plan is integral. These multiprofessional documents are supported by clinical governance and quality agendas within healthcare organisations in delivering effective outcomes [DH 1998].

Activity 1.2

Using the template below, identify concepts related to care planning. We have given you some ideas for the first letter of each word.

Child-centred care
A______________
R______________
E______________

Process guided by model(s) of care
L______________
A______________
N______________
Philosophy of care

This aspect of professional practice relates to the expectation of service users and nursing staff in a particular clinical environment of how care and services will be organised and delivered. A philosophy of care helps nurses to define their role and guide practice, within a growing diversity of roles in the clinical environment. Children’s nursing, as a distinct field of practice, may relate to a philosophy of care that recognises the individuality of each child and their family, understanding their unique needs in relation to healthcare provision and ensuring their involvement in decisions about their care. The child’s needs must be paramount, whether physical, psychological, social, cultural or spiritual, as well as those of their family, and these should be embedded in the philosophy of care within the clinical environment (RCN 2003).

Activity 1.3

Seek out the philosophy of care in your clinical placement:

- Enquire from ward manager how this ward philosophy was created.
- Does it identify what children and their families can expect from the service?

What are nursing models?

Nursing models, which are also known as grand theories, attempt to illustrate the theory of nursing practice and facilitate the children’s nurse to organise and deliver care. When applied to practice these models of care influence the performance of the nurse and the experience for the child and family (McGee 1998; Pearson et al. 2005). The construction and application of nursing models support the development of nursing practice, whilst recognising the values, beliefs and culture of the individual and the changing clinical environment.

Since early work by Fawcett in 1984, numerous nursing models identify the four components of a model as:

- The person
- Their environment
- Health
- Nursing

Care is organised and delivered around identified deficits relating to these components. The development of nursing models, aims to enhance the delivery of family-centred care whilst facilitating the experienced children’s nurse to practice autonomously. Through engagement with the child and family the children’s nurse is able to identify needs and create a plan of care for the individual and their family, when employing the nursing process in conjunction with a model/s of care.
**Table 1.1** An adaptation of the Roper, Logan and Tierney Model of Nursing (1985).

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Risk management</td>
<td>Difficulties with hearing, sight or speech</td>
<td>Respiratory problems</td>
<td>Special diets</td>
</tr>
<tr>
<td>Medications</td>
<td>Cognitive disability</td>
<td>Cardiac conditions</td>
<td>Alternative feeding methods</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>Interpreter services required</td>
<td>Compromised airway</td>
<td>Swallowing difficulties</td>
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</thead>
<tbody>
<tr>
<td>Altered function of bowel/bladder</td>
<td>Level of dependence</td>
<td>Abnormal body temperature</td>
<td>Level of independence</td>
</tr>
<tr>
<td>Infections</td>
<td>Skin integrity</td>
<td>Regulatory disorders</td>
<td>Mobilising disabilities</td>
</tr>
<tr>
<td>Structural anomalies</td>
<td>Personal preferences</td>
<td>Environmental factors</td>
<td>Use of aids</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Relevant to age</td>
<td>Stage of development</td>
<td>Altered sleep patterns</td>
<td>Relevance to illness</td>
</tr>
<tr>
<td>Effects of hospitalisation/illness</td>
<td>Altered body image</td>
<td>Sleeping aids</td>
<td>Fear of dying</td>
</tr>
<tr>
<td>Hobbies/interests</td>
<td>Sexual preferences</td>
<td>Environmental factors</td>
<td>Spiritual needs</td>
</tr>
</tbody>
</table>

**Roper, Logan and Tierney – the 12 activities of living model**

This conceptual model of nursing was devised by three United Kingdom-based nurses and is widely recognised both nationally and internationally. The model is practice orientated whilst incorporating a theoretical framework for care delivery. The model relates to the lifespan of the individual, identifying twelve activities of living (see Table 1.1), which are considered in relation to the continuum of dependence to independence throughout life, appreciating aspects of age, environment and circumstances which may impinge on this continuum. Each activity of living is influenced by five identified factors, which are biological, psychological, socio-cultural, environmental and politico-economic (Roper et al. 1985). This model is used in conjunction with the nursing process to identify actual and potential problems for the individual and how nursing care can advance the patient along the dependence to independence continuum. This model of care will be utilised in subsequent chapters such as Chapter 22, illustrating its application in care planning.

**Family-centred care**

Child and family-centred care has become a central tenet of children’s nursing and other health professionals’ practice, it is viewed as a multifaceted concept that has evolved over the last 60 years (Coleman 2010). Various attributes of family-centred care are identified in the nursing literature, and include collaborative working, partnerships, respect and involvement of family, negotiation, empowerment/engagement and provision of a family friendly environment (see Figure 1.2). Whilst there is no clear definition, this concept of family-centred care (FCC) has continued to grow and develop a body of evidence to support its utilisation in contemporary children’s nursing practice, since the earlier work of Casey (1988; 1995). The evolvement of the concept FCC and its theoretical underpinnings can be sourced in early work by psychologists Bowlby (1953) and Robertson (1958) who recognised the damaging effects of maternal deprivation and separation caused by hospitalisation, on
These important findings were later endorsed and supported in the findings and recommendations presented by the Platt Report (Ministry of Health 1959).

The development of a national association by parents in 1961 (National Association for the Welfare of Sick Children in Hospital [NAWCH]: http://www.nch.org.uk/ourservices/index) gave parents a voice to demand services which recognised them as central caregivers to their children. This further supported and challenged the need for healthcare delivery for children and their families, to change from a medically dominated service to a service responsive to the needs of children and their families, which provided facilities for parents to remain with their hospitalised child. Recognising and supporting the family as central care providers alongside children’s nurses, requires respect for the integrity of the family unit, whatever its structure, with the provision of services which are responsive to the needs of the child and family [United Nations [UN] 1989; Department of Health [DH] 2003]. The notion of children, families and children’s nurses as partners in care delivery is integral to achieving the best plan of care and promotes functioning at the highest possible level (Gance-Cleveland 2006). Indeed, Shields et al. (2006) suggest FCC aims to plan and deliver care not just to the child but to the family as a whole, and all family members are recognised as care recipients.

Figure 1.2 Attributes of family-centred care.
Governmental policies have identified the importance of involving parents in the care of their children and identified this as a major theme in the development of services (Audit Commission 1993; DH 1991; 1996). Further progress has led to the demand for service users, including parents and children, to have a greater voice in shaping future services as identified in more recent literature (DHPSSPS 2005; Noyes 2000). Conversely, Bradshaw et al. (2000/2001) suggest delivering FCC is challenging and demanding, requiring the children’s nurse to possess a range of complex skills to ensure its implementation in practice is effective, whilst proposing the theory of FCC has advanced ahead of clinical practice to the detriment of its operationalisation. The lack of a nursing model to support the implementation of this concept in children’s nursing is identified by Coleman (2002) as a contributory factor in the difficult translation of the concept from theory to clinical practice.

The lack of involvement of children and their families in the decision-making process regarding their care provision, as perceived by children and their parents, has been identified within nursing literature (Kawik 1996; Noyes 2000). To address this issue children’s nursing must relinquish power in relation to the service they provide and embrace parents as partners in care provision, through the recognition of children and their parents as service users (Cardwell 2006). Their involvement in the design and development of services to meet their individual needs is vital in ensuring an equitable service irrespective of regional, cultural or socio-economical status.

The Mead model

This model was developed for the intensive care setting and for practical use at the bedside. Mead’s framework was adapted from the Roper et al. (1985) nursing model, with which it shares some of its attributes. In addition to knowledge and experience of the intensive care environment, the nurse must be familiar with Roper’s model, to ensure care planned is delivered in an effective manner. This adapted model identifies the individuality, lifespan [age], dependence/independence and needs of the patient as the aspects to be assessed when planning care. Factors which impact on the health and wellbeing of the individual are similar to those identified by Roper et al., namely physical, psychological, environmental, socio-cultural and politico-economical. Additionally, within the dependent/independent continuum on the nurse, Mead (McClune and Franklin 1987) identifies five stages:

1. Total dependence
2. Intervention
3. Intervention with some prevention
4. Prevention
5. Total independence

Each patient is continuously evaluated within the continuum in relation to the five factors highlighted above, identifying appropriate goals for the patient and progression towards independence, with cognisance of the patient’s lifespan position. In conjunction with the nursing process the nurse is able to devise a plan of care unique to the needs of the individual patient. In devising a care plan, physical care needs are subdivided into elements specific to the intensive care environment. These include: respiratory, cardiovascular, pain sedation, neurology, nutrition, elimination, skin care, mobility, psychological and social/cultural and circumstantial (Viney 1996). To illustrate the
The Nature of Care Planning and Nursing Delivery for Infants, Children and Young People

1. Stages on the dependence/independence continuum, which are relevant to the neurology element as identified in the Mead model, see Table 1.2 which is linked to care planning in Chapter 16.

**Table 1.2** Stages on the neurology dependence/independence continuum.

<table>
<thead>
<tr>
<th>Criteria for stages on neurology continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unstable neurological state, requiring continuous monitoring.</td>
</tr>
<tr>
<td>2. Potentially unstable neurological state, requiring frequent monitoring.</td>
</tr>
<tr>
<td>3. Potentially unstable neurological state, requiring monitoring.</td>
</tr>
<tr>
<td>4. Stable neurological state, requiring monitoring to detect/prevent deterioration.</td>
</tr>
<tr>
<td>5. No assistance required to maintain neurological state.</td>
</tr>
</tbody>
</table>

**Table 1.3** Self-care requisites (Orem 1995).

**Universal self-care requisites**

Universal self-care requisites are associated with the maintenance of human functioning and serve as a framework for assessment (Cutliff et al. 2010):

- The maintenance of a sufficient intake of air.
- The maintenance of a sufficient intake of water.
- The maintenance of a sufficient intake of food.
- The provision of care associated with elimination processes and excrements.
- The maintenance of a balance between activity and rest.
- The maintenance of a balance between solitude and social interaction.
- The prevention of hazards to human life, human functioning and human wellbeing.
- The promotion of human functioning and development within social groups in accordance with human potential, known human limitations and the human desire to be ‘normal’. Orem calls this ‘normalacy’ (see Chapter 21).

**Developmental self-care requisites**

Developmental self-care requisites are related to developmental processes throughout the life cycle and can include physical, social or psychological changes, i.e. adolescence or social life changes such as bereavement.

**Health deviation self-care requisites**

Arise out of ill health or injury and are associated with the effect and changes of disease or trauma on the individual.

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Stages on the dependence/independence continuum, which are relevant to the neurology element as identified in the Mead model, see Table 1.2 which is linked to care planning in Chapter 16.

**Orem’s self-care model**

The self-care model of nursing was developed by Dorothea Orem (between 1959 and 2001) with the aim of helping the patient and family achieve self-care (Walsh 1998). The Orem model is based on the premise that individuals have self-care needs which they themselves have an ability and right to meet except when their ability to do so has been compromised (Pearson et al. 2005). When undertaking a comprehensive assessment this self-care model identifies what care the patient or family can do for themselves (Nevin et al. 2010). The model has three key concepts: self-care, self-care deficit and nursing systems. Self-care concerns the various activities individuals carry out on their own behalf in maintaining life, health and wellbeing, which Orem (1995) categorises as universal self-care requisites, developmental self-care requisites and health deviation self-care requisites (Table 1.3), and
also identifies actions for meeting the universal self-care requisites. According to Orem the person best placed to meet these requisites is the individual themselves, whom she calls the self-care agent. In the case of an infant and child this would be the parents; Orem calls this dependent care (Orem 1995). When in an individual or, in the case of a child, a parent the demand for self-care is greater than the individual or parent’s ability to meet it then a self-care deficit occurs and nursing may then be required.

Orem (1991) identifies four goals of nursing:

- Reducing the self-care demand to a level whereby the individual or parent is able to meet the demand independently.
- Increasing the individual or parent’s capacity or ability to meet the demand independently.
- Enabling the individual or parents (or significant others) to give dependent care when self-care is impossible for the individual or parent.
- The nurse meets the individual or parent’s self-care demand directly.

Orem (1995) also refers to the role of the nurse within nursing systems, which are carried out on one of three levels:

- Total compensatory system – the nurse provides all the patient care.
- Partial compensatory system – nurse assists with care of patient.
- Educative/supportive system – patient has control over their health.

Although the children’s nurse may find this self-care theory process time consuming, the overall aim is that the young person or parent is able to meet most of their needs with supportive education. Therefore the nurse’s role is one of teaching and supporting in order to meet the self-care need.

**Activity 1.4**

To read more on Orem’s self-care model, please review the following texts:

**Neuman’s systems model**

Betty Neuman, an American nurse devised this theoretical model of nursing which places great emphasis on prevention (primary, secondary and tertiary), interventions and a systems
approach to holistic wellness (Neuman & Young 1972). The overall focus of this model is the total wellness of the person in attaining and maintaining health to a maximum level. Neuman’s model identifies three types of stressors (intrapersonal, interpersonal and extrapersonal) that act on five individual variables, namely physiological, psychological, sociocultural, spiritual and developmental aspects, which interrelate with each other. This model is easily adapted to the community setting where the wider contextual (environmental) factors affecting individual health need consideration, and are fundamental to service provision. When used in conjunction with the nursing process this model aims to support the stability of the person. For further discussion please see Chapter 17.

Summary

This chapter has attempted to outline some of the nursing models in contemporary practice within children’s nursing, which will be applied to clinically based care planning scenarios within this book. These nursing models have been summarised in Chapters 1–10 and then analysed within care planning scenarios (Chapters 12–37) with emphasis on assessing the individual needs of infants, children and young people. The children’s nurse has also been introduced to several reflective activities. An appreciation of other nursing models such as the Nottingham model (Smith 1995) and its application in clinical practice is also encouraged, to help enhance knowledge and understanding of care planning.

Care of the child and family during illness: student perspective

Scenario

Oliver Love (a pseudonym), aged four months, was taken this afternoon to his GP by his parents with a history of being unwell for the past 24 hours with a troublesome cough and difficulty with breathing. The GP diagnosed Oliver as suffering from croup, so he was quickly referred to the children’s medical ward for admission and further management. On arrival at hospital, Oliver was accompanied by his six-year-old sister and anxious parents. Whilst establishing Oliver’s clinical observations the children’s nurse noted sudden deterioration in his condition.

Proposed care plan

Using the care plan sheets provided, two key activities of living (A/L) requiring immediate attention were selected by the nursing student and goals identified. A plan of care for Oliver and his family was constructed, supported with rationale, relating to the nursing process and Roper et al. (1985) model of nursing, incorporating a family-centred approach to care and reference to literature.

Sample care plan

Child’s Name: Oliver Love  DOB: 8 December 2010

continued
<table>
<thead>
<tr>
<th>Date and time</th>
<th>A/L No</th>
<th>Potential/actual problems</th>
<th>Nursing objectives/outcomes/goals</th>
<th>Nursing care plan (actions with rationale)</th>
<th>Review dates</th>
<th>Nurse’s signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/12/2011 16.00hrs</td>
<td>No.3</td>
<td>Oliver has been admitted to the ward with a troublesome cough and difficulty with his breathing – differential diagnosis is croup.</td>
<td>Ensure Oliver is nursed safely and effectively to maintain patency of his airway, relieve cough and return breathing pattern to within normal limits.</td>
<td>Approach Oliver and his family in a calm and friendly manner; introduce them to the ward, try to reassure parents and keep them informed. Nurse Oliver upright, prop with pillows to increase his lung capacity and beside working oxygen and suction in case of an emergency situation. If Oliver is unsettled his mum may nurse him on her lap, though handling should be avoided. Use the ABC approach (Resuscitation Council UK 2010). Assess Oliver’s respiratory function – initially assess patency of his airway using look, listen and feel approach, gently check for any obstruction or signs of inflammation and distress. Next assess Oliver’s breathing – record and monitor his respiratory rate, rhythm and depth of breaths; note respiratory effort, e.g. if indrawing, nasal flaring or tracheal tug. Important to assess Oliver’s cough, recording frequency and effects it has on Oliver’s breathing (Holland et al. 2008).</td>
<td></td>
<td>Std Nurse L. Hughes</td>
</tr>
</tbody>
</table>
Check Oliver’s oxygen saturations – if less than 92% consult doctor and administer humidified oxygen at a rate of 5 litres per minute initially, record response and adjust accordingly [BNFC 2010-2011].
Assess Oliver’s circulation – check and monitor his capillary refill time. Note any signs of cyanosis, e.g. mottled skin appearance and check body temperature. Record and report accordingly [NMC 2008].
Administer medication [e.g. adrenaline or steroid via nebuliser] as prescribed by doctor and as per ward policy – check against six rights of administration [Olsen et al. 2010] and medicine guidelines.
Carry out oral and nasal hygiene as and when required – should Oliver produce secretions obtain a specimen and send to laboratory for culture and sensitivity.

9/12/2011 16.00hrs

No.2 Oliver’s parents are very anxious about his condition.

Ensure Oliver’s parents are well informed about his condition, in order to reduce their fears and anxieties.

Welcome Oliver and his parents to the ward.
Introduce Oliver and his parents to their primary nurse who will show them the facilities available and inform them of visiting times for extended family.
Accompany doctor when he explains to parents the effects croup will have on Oliver and be aware that his parents may want answers to questions.

Std Nurse L. Hughes
<table>
<thead>
<tr>
<th>Date and time</th>
<th>A/L No</th>
<th>Potential/actual problems</th>
<th>Nursing objectives/outcomes/goals</th>
<th>Nursing care plan (actions with rationale)</th>
<th>Review dates</th>
<th>Nurse's signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide Oliver’s parents with both written and verbal information on croup – encourage parents to participate in Oliver’s care. Establish a therapeutic relationship with Oliver and his parents, work in partnership to help meet holistic needs (Casey 1995). Oliver is in the sensorimotor stage of development, so the children’s nurse needs to be aware of his needs throughout hospitalisation (Bee &amp; Boyd 2007). Contact play therapist who can provide suitable toys for Oliver during his stay in hospital. Complete a detailed history from Oliver’s parents, in order to accurately assess and develop a plan of care and aid diagnosis.</td>
<td></td>
<td></td>
<td>Std Nurse L. Hughes</td>
</tr>
</tbody>
</table>

Care plan by second year Child branch Nursing Student, Lisa Hughes.
References


Nursing & Midwifery Council (2010) *Standards for Pre-registration Nursing Education.* London: NMC.


