## Planned Care (complete on all patients on arrival to the ward and revise WHEN CARE CHANGES)

### Nursing care

<table>
<thead>
<tr>
<th>Initial Care</th>
<th>Revised Care</th>
<th>Revised Care</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Date: <em><strong>/</strong></em>/____</td>
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</tr>
</tbody>
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#### Checklist/clinical pathway being used (if any)

#### Interval of standard observations (as per SPOC)

#### Oxygen therapy

- [ ] NO
- [ ] YES

#### Special observations in addition to SPOC (e.g. PCA, BGL, neuro, neurovascular, traction)

#### Nutritional needs (e.g. diet, frequency, method & assistance)

#### Toileting (e.g. nappies / toilet training, assistance)

#### Hygiene (e.g. skin integrity, assistance)

#### Mobility (e.g. aids, assistance)

#### Pressure area care

<table>
<thead>
<tr>
<th>Score:</th>
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</tr>
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<tbody>
<tr>
<td>Risk level:</td>
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#### Skin inspection

- [ ] NO
- [ ] YES

#### Falls risks

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<th>Score:</th>
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<th>Score:</th>
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</thead>
<tbody>
<tr>
<td>Routine</td>
<td>Routine</td>
<td>Routine</td>
<td>Routine</td>
</tr>
<tr>
<td>High risk</td>
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#### Safety and security (e.g. cot sides / bed rails, SIDS & Kids Safe Sleeping)

#### Infection prevention & control - standard & transmission based precautions

- Standard
- Droplet
- Contact
- Airborne

#### PIVC / CVAD / IVT Care

#### Other care

#### Care discussed with parent / carer

- [ ] NO
- [ ] YES

#### Assigned nurse to sign when care revised

<table>
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<tr>
<th>Sign:</th>
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<th>Sign:</th>
</tr>
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<tbody>
<tr>
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### Healthcare Provider
- **Checklist/clinical pathway being used (if any)**
- **Interval of standard observations (as per SPOC)**
- **Oxygen therapy**
  - NO
  - YES
- **Special observations in addition to SPOC**
  - (e.g. PCA, BGL, neuro, neurovascular, traction)
- **Nutritional needs**
  - (e.g. diet, frequency, method & assistance)
- **Toileting**
  - (e.g. nappies / toilet training, assistance)
- **Hygiene**
  - (e.g., skin integrity, assistance)
- **Mobility**
  - (e.g. aids, assistance)

### Pressure Area Care
- **Score:** __________
- **Risk level:** _______
- **Score:** __________
- **Risk level:** _______
- **Score:** __________
- **Risk level:** _______
- **Score:** __________
- **Risk level:** _______

### Skin Inspection
- **NO**
- **YES**
- **NO**
- **YES**
- **NO**
- **YES**
- **NO**
- **YES**

### Falls Risks
- **Score:** __________
- **Routine**
- **High risk**
- **Score:** __________
- **Routine**
- **High risk**
- **Score:** __________
- **Routine**
- **High risk**
- **Score:** __________
- **Routine**
- **High risk**

### Safety and Security
- (e.g. cot sides / bed rails, SIDS & Kids Safe Sleeping)
- **Infection prevention & control - standard & transmission based precautions**
- **Standard**
- **Droplet**
- **Contact**
- **Airborne**

### PIVC / CVAD / IVT Care

### Other care

### Care discussed with parent / carer
- **NO**
- **YES**
- **NO**
- **YES**
- **NO**
- **YES**
- **NO**
- **YES**

### Assigned nurse to sign when care revised
- **Sign:** __________
- **Time:** ____:____hr
- **Sign:** __________
- **Time:** ____:____hr
- **Sign:** __________
- **Time:** ____:____hr
- **Sign:** __________
- **Time:** ____:____hr

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*Facility: PAEDIATRIC NURSING CARE PLAN (EXTENDED STAY)*

*COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE*

*FAMILY NAME* | *MRN* |
---|---|

*GIVEN NAME* | *□ MALE □ FEMALE* |

*D.O.B. _____ / _____ / _______ M.O.*

*ADDRESS* | *LOCATION / WARD* |

*SMR060996!Ä*