

SURNAME _____ NHI _____

FIRST _____

DATE OF _____ / _____ / _____ SEX _____

Please attach patient label here



Family members participating in Care Plan:

Date / Time	Goal	Expected Outcomes	Individualised Care Needs	Revision, Date & Time, Name & Signature	Signature Nurse and Family
	Family Centred Care	<ul style="list-style-type: none"> Family are orientated to the area and facilities Families are enabled and encouraged to ask questions and participate in care Complete "My name is" poster at bedside Identify estimated discharge date Key family support member is identified and documented Identified social and cultural requirements Family have identified specific cultural considerations and they are in place Cultural support provided at family meetings Care is negotiated with caregivers on a shift by shift basis and family are aware of care plan Activities of daily living (ADLs) are planned daily with families meeting the needs of the individual child with consideration to development Families are fully conversant in all aspects of their child's care and are fully prepared to confidently care for child post discharge 			
	Pain and comfort assessment and management	<ul style="list-style-type: none"> Identify child's known response to pain and comfort strategies Identify on a daily basis potential sources of pain and discomfort including pre and post procedural management 			



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		<ul style="list-style-type: none"> • Undertake pain assessment in discussion with child and/or caregiver complimented with an age appropriate pain scale • Identify and implement any non-pharmacological approaches or techniques • Identify and administer appropriate analgesic requirements • Evaluate effectiveness of interventions and escalate further analgesic requirements • Clinical care reviews provide the opportunity to assess pain on a regular basis 			
	Child will participate in activities/play appropriate to their developmental level	<ul style="list-style-type: none"> • Explain all procedures to patient and family • Where possible involve family in all cares • Encourage patient to take control when possible (establishing care routines, dietary choices, activities) • Position child to see surroundings and activities • Involve play therapist/ adolescent play therapist • Try to maintain a normal environment: <ul style="list-style-type: none"> – Sleep Routine – Own toys – School • Ensure call bell is within reach at all times 			



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	Maintain regular bowel elimination pattern	<ul style="list-style-type: none"> • Involve dietician into child's care day 1 post-op • Maintain strict FBC, including food record • Encourage oral intake of fluids • Encourage fruit, vegetables and high fibre diet • Record all bowel movements on chart • Give prescribed laxatives regularly 			
	Maintain skin integrity	<ul style="list-style-type: none"> • Refer to Guideline for Pressure Injury Prevention for an Infant, Child or Young Person • Complete Glamorgan paediatric pressure injury risk assessment scale and implement appropriate Bundle of care • Ensure regular change of position 2-3 hourly and record on chart • Ensure all joints and limbs are in correct alignment • Liaise with physiotherapists with cares including R.O.M exercises and care of limbs • Assist with ADLs daily • Check traction integrity each shift, including jacket if applicable • Liaise with Orthotics for liner change if in a Halo Jacket. Check for pressure areas under jacket 			
	Minimise and monitor for potential complications	<ul style="list-style-type: none"> • Clean pin-sites 48 hours post insertion then daily, assessing the pin-sites for signs of infection and 			



Starship
Child Health
Halo Traction Care Plan

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	while in halo traction. i.e. Infection and nerve palsy of sixth cranial nerve	movement <ul style="list-style-type: none"> • Administer I.V. antibiotics as prescribed • Ensure all weights are off the floor, if weights are required. Ensure the traction has the correct weight for the child. No more than 39% of the child's body weight unless specified by the orthopaedic medical team • Maintain counter traction by tilting the end of the bed facing downwards, against the weights • Watch for signs of nerve palsy <ul style="list-style-type: none"> – Speaking difficulties – Dysphagia or – Dysarthria – Drooping tongue – Report to team a.s.a.p. if signs of nerve palsy noted 			
	Discharge planning and preparation	<ul style="list-style-type: none"> • Discuss with family on daily ward round estimated date of discharge • Assess discharge needs and supports with family and MDT and begin preparation for discharge early including referrals, equipment, medications and education • Infectious concerns • Discuss implications with family for: <ul style="list-style-type: none"> ○ Return to school/early childhood centers/Kohanga Reo 			

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		<ul style="list-style-type: none"> ○ Returning to normal level of daily activities (inclusive of group and cultural activities) ● Check immunisation status and opportunistically immunise ● Arrange discharge meeting if required ● Educate family on normal course of illness, concerning signs and symptoms of recurrence and how and where to seek help ● Follow up referrals and appointments specific to presentation: <u>hearing assessment</u> 			