

SUPPLEMENTARY MATERIALS

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ARKANSAS TECH UNIVERSITY
 Department of Nursing
 NUR 3805 ~ Practicum II

PEDIATRIC ASSESSMENT FORM

Patient Initials: _____ Date of Birth: _____ Age: _____ Male or Female

Allergy and Reactions: _____ NKDA

Height	Inches	% Growth Chart
Weight	Pounds KG	% Growth Chart
Head Circumference if <2 years of age	Inches	% Growth Chart

Medical Diagnose(s):

Significant Past Medical History to include Birth History if <2 years of age:

Immunization Status:

- Up to date
- Identify deficient immunizations and why: _____

NUTRITION

Type of Diet: _____ Breast OR Formula Type: _____ N/A
 Bottle OR Sippy Cup N/A Supplement(s): _____ N/A
 Special Dietary Needs or Restrictions (WHY?):

USUAL 24 HOUR NUTRIENT INTAKE (meals; what foods, how much?)	HOSPITAL NUTRIENT INTAKE

Factors affecting (circle): Nausea Vomiting Anorexia Restrictions Cough Other (list)*

Last Bowel Movement	Characteristics:
Usual Home Defecation Pattern	Characteristics:
Hospital Urination Pattern	Characteristics:
Usual Home Urination Pattern	Characteristics:

INTAKE / OUTPUT

<p><i>24 Hour Fluid Requirement:</i> 100cc x first 10kg 50cc x next 10kg 20cc x remainder of weight in kg SHOW YOUR MATH →</p>	<p>Calculate: _____ kg</p> <p><input type="checkbox"/> N/A if >70KG</p>
<p>Shift Fluid Requirement: <input type="checkbox"/> 8 hour</p>	<p>Calculate:</p>
<p>Hourly Fluid Requirement: Divide 24 hr. requirement by 24 =</p> <p>IV Fluid: _____</p> <p>@ _____ cc/hour</p> <p>Tubing Change Due: _____</p>	<p>Calculate:</p> <p>COMPARE HOURLY FLUID REQUIREMENT TO IV RATE:</p> <p><input type="checkbox"/> Heplock <input type="checkbox"/> No IV</p>
<p><i>24 Hour Output Requirement:</i> 0.5 – 2cc/kg/hour</p>	<p>Calculate:</p> <p><input type="checkbox"/> N/A if >30cc hour</p>
<p>Shift Output Requirement: <input type="checkbox"/> 8 hour</p>	<p>Calculate:</p>

VITAL SIGNS

VITAL SIGNS	YOUR SHIFT	HOSPITAL STAY LOWEST	HOSPITAL STAY HIGHEST
Temperature			
Pulse			
Respiration			
Blood Pressure			
Oxygen Saturation			

RESPIRATORY

Breath Sounds:

Respiratory Effort:

Cough:

Response to respiratory treatments: N/A Oxygen Saturation _____

ACTIVITY

Amount of usual exercise: N/A (infant)

Self-care deficit(s): N/A (infant)

Identify and describe therapeutic play activities appropriate for this child during hospitalization:

Describe play behaviors you observed:

Discuss age appropriate safety measures:

SKIN INTEGRITY

Describe skin and mucous membrane integrity to include IV site:

SLEEP AND REST PATTERN

Sleep requirement for age: _____

Usual 24 hour pattern: _____

Last 24 hour pattern: _____

PAIN

Circle Pain Scale: CHEOPS NIPS RIPS

Pain Score: _____ Describe Characteristics: _____

Usual relief methods and effectiveness: _____

GROWTH & DEVELOPMENT

	Gross/Fine Motor	Socialization	Language
Identify Observed Behaviors <input type="checkbox"/> N/A - Adolescent			

Sensory Deficits: _____ None

Anxiety / Fear: _____

Developmental Delay for Age: _____

_____ None

FAMILY

Parents: Married Single Divorced Other _____

Siblings: _____

Observed family processes (parenting, sibling, other family roles and relationships):

Social Interaction and/or Isolation:

Healthcare Values and Beliefs:

Spiritual: _____

TEACHING

Identify at least three teaching points for the parent and/or child (anticipatory guidance, illness prevention, safety, etc.). Highlight any teaching completed during clinical.

1. _____

2. _____

3. _____

Patient Initials: _____ Age: _____
 Weight: _____ kg
 Diagnose(s): _____

ARKANSAS TECH UNIVERSITY
 Department of Nursing
Pediatric Practicum Sheet

Student: _____
 Date: _____

<u>Normal</u> PEDIATRIC physiology based upon the patient's diagnosis:	<u>Alteration</u> in PEDIATRIC physiology based upon the patient's diagnosis (Define & Describe, S/S, treatment, etc):	PEDIATRIC NORMS (based upon the patient's age)
		<ol style="list-style-type: none"> 1. Nutritional Needs: Kcal/kg if on formula or food guide pyramid for older child. 2. Vital Sign Ranges for Age 3. Motor Development 4. Language & Speech Development 5. Erikson's Stage 6. Immunizations required for this age 7. Stage of Play (solo, parallel, cooperative, or competitive)
SOURCE:	SOURCE:	

Patient Wt. _____ kg

MEDICATIONS

Medication	Ordered Dosage & Route	Recommended Dosage (mg/kg)	Weight Based Dosage Calculation (mg/kg) SHOW YOUR MATH!	Safe Y/N	Why is patient receiving?	Major Side Effects & Nursing Implications

MEDICATIONS FOR PEDIATRIC ROTATION

The following list includes some commonly prescribed pediatric medications. The student is required to prepare medication cards before their first day of pediatric practicum and maintain throughout the clinical rotation.

Albuterol
Amoxicillin
Ampicillin
Augmentin
Ibuprofen
Prelone Syrup/Prednisone Tabs
Pulmicort
Rocephin
Singulair
Solu-Medrol
Tylenol
Xopenex
Zithromax

Important Pediatric Measurement Conversions:

5cc = 1 teaspoon
3 tsp = 1 tablespoon
15 cc = 1 tablespoon
30 cc = 1 ounce
1 kg = 2.2 pounds
2.5 cm = 1 inch
1 mcg = 0.001mg
1mL = 1cc
1 gram = 1cc

Pediatric Dosage Calculation EXAMPLE:

Amoxil 40mg/kg/day divided TID

The patient weighs 15 kg.

This drug comes in the concentration of 250mg/5cc.

How many mg per dose? How many cc's per dose?

$$40 \text{ mg} \times 15 \text{ kg} = 600 \text{ mg per day}$$

$$600 \text{ mg} \div 3 = 200 \text{ mg per dose}$$

$$200 \text{ mg} \div 250 \text{ mg} = 0.8 \text{ mg}$$

$$0.8 \text{ mg} \times 5 \text{ cc} = 4 \text{ cc per dose}$$

Arkansas Tech University
School of Nursing
Postpartum Assessment

Student Name: _____

IDENTIFYING DATA

Date: _____

Pt initials: _____ Age: _____ Race: _____

Occupation: _____ Medical Diagnosis: _____ Delivery Type: _____

FATHER Age: _____ Race: _____ Occupation: _____

Pertinent Past Medical History of Patient:

RESPIRATORY

Respirations: Rate _____ Depth _____ Quality _____

Breath Sounds: _____

History of Dyspnea (caused by): _____ Cough productive/nonproductive

Bronchitis Asthma URI (recent) Other: _____

Smoker: yes/no Pk/day: _____ No. of years: _____

CIRCULATORY

B/P: _____ Pulse: _____ Heart Sounds: _____

Homans: positive/negative

Peripheral Pulses: Radial: _____ Dorsalis pedis: _____

FOOD/FLUID

Prepregnancy wt: _____ Pregnancy wt: _____

Height: _____ Skin turgor: _____

Mucus membranes: _____ Nausea/Vomiting: _____

Edema:(specify) _____

Prescribed diet: _____ Appetite: _____

Food preferences/restrictions: _____

Current intake IV solution: _____ cc's (24hr): _____

Fluid intake cc's (24hr): _____ Meal %: _____

ELIMINATION

Usual bowel pattern: _____ Laxative use: _____

Last bowel movement: _____ Bowel sounds: _____

Hemorrhoids: _____

Difficulty voiding: _____ Bladder papable: _____

Foley catheter: _____ Protein(if applicable): _____

Output: Urine(cc's): _____ Estimated Blood Loss: _____ Other: _____

Urinalysis report: _____

PAIN/COMFORT

Location: _____ Quality: _____ Duration: _____

Precipitating factors: _____ Guarding: _____ Facial Grimace: _____

Pain Scale: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Focused Assessment For Complicated Pregnancies/Deliveries

Condition: _____

Assessment: _____

HYGIENE

General Appearance: _____

Skin/Hair: _____

Body odor: _____ Vermin: _____ Teeth/gums: _____

ACTIVITY/REST

Sleep pattern: _____

Usual activities: _____

Prescribed activity: _____ Activity tolerance: _____

Gait: _____ Range of motion: _____

SAFETY

Temperature: _____ Hgb&Hct (Pre Delivery& Post Delivery): _____ Rubella Titer _____

_____ HIV: _____ Hep. B: _____ Group B Strep: _____

(Serology – Syphilis) _____ Whitecount: _____

Blood Type: _____ Coombs: _____ CBC: Platelets: _____

Allergies: _____

BREAST Breast or Bottle Feeding (circle one)

Bra: _____ Nipples (shape,condition): _____

Colostrum: _____ Latching on: _____

Any equipment used to aid in Nursing? _____

UTERUS

Fundus: Consistency: _____ Height: _____ Position: _____

Lochia: Color: _____ Amount: _____ Clots: _____

Redness/or drainage: _____ IF antepartum FHT's _____

Episiotomy/Lacerations: Type _____ Swelling _____

Redness/or drainage: _____

Surgical incision: Appearance: _____

Type: _____ Dressing: _____

SEXUALITY

Menarche: _____ Frequency: _____ Duration: _____

Amount: _____ LMP: _____

Pap smear: _____ Contraceptives: _____

Self Breast Exam: _____

Gravida: _____ Para: _____ Abortions: _____

Term: _____ Preterm: _____ Living: _____

Complications (maternal/fetal): _____

SOCIAL INTERACTION/EGO INTEGRITY

Pregnancy planned (Y/N): _____

Client/father adjustment to newborn: _____

Marital Status: _____ Living With: _____

Role within family structure: _____

Extended family/other support: _____

Financial Concerns: _____

Religion: _____ Cultural Factors: _____

Report stress factors: _____

Emotional status: (check those which apply) Calm Anxious Angry Depressed

Fearful Irritable Resistive Other(specify): _____

Verbal/nonverbal communication with family/significant other: _____

Bonding behavior: _____

NEUROSENSORY

Hearing Aid: _____ Glasses: _____ Contacts: _____

Headaches: Location: _____ Frequency: _____

Seizures: _____ Reflexes: _____

MEDICATIONS (List all routine and prn meds)

Drug name/mg	How prescribed	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TEACHING/LEARNING

Educational background (mother/father): _____

Previous childbirth experience: _____

Preparation: Books _____ Classes _____

Learning needs identified by client: _____

Learning needs identified by Nurse: _____

Referrals: _____

In Hospital/Discharge teaching: _____

NURSING CARE PLAN

DATE	NURSING DIAGNOSIS	PLAN (Outcome)	IMPLEMENTATION	RATIONALE	EVALUATION

**MEDICATIONS FOR WOMEN'S
CENTER**

The student is expected to maintain a drug card on each of the medications ordered for their assigned client. It is the responsibility of the student to know and understand the drugs. The following list are some of the common drugs used. This list is provided so the student will prepare their medication cards before or very early in the practicum experience.

DRUGS		
ATIVAN	AQUAMEPHYTON	ALKA-SELTZER GOLD
AMPICILLIN	CA GLUCONATE	ANAPROX DS/ ANAPROX
ANCEF	APRESOLINE	ATROPINE
BENADRYL	BRETHINE (TERBUTALINE)	RHOGAM
DEMEROL	DARVOCET	CERVIDIL
DURAMORPH	NALTREXONE	ERYTHROMYCIN
GENTAMYACIN	Toradol	HEMABATE
KEFLEX	LASIX	CYTOTEC
MACRODANTIN	METHERGINE	NARCAN (NALOXONE)
MAGNESIUM SULFATE	MILK OF MAGNESIA	PITOCIN
PENICILLIN	CLAFORAN	SLOW FE
PERI-COLACE	PHENERGAN	TYLENOL
REGLAN	Bicitra	VICODIN
STADOL	FENTANYL	ZANTAC
VALIUM	TYLENOL ES	XYLOCAINE
VISTARIL	HEP B	DULCOLAX
ROBINAL	MMR	MORPHINE
VERSED	TYLOX/PERCOCET	
ZOFRAN		

PREP FORM FOR NEWBORN NURSERY

1. Discuss the risk for respiratory and cardiovascular complications in the newborn.

2. Discuss the risk for heat loss in the newborn and what nursing interventions are used to prevent them.

3. Discuss the pathophysiology in regards to newborn jaundice. Also discuss the different types/causes of jaundice and treatment.

4. Discuss elimination patterns of the newborn.

5. Complete the clinical significance for the assessment of the newborn.

6. Describe the process of assigning APGARS at birth.

7. Summarize the indication and use of Vitamin K, Hepatitis B, and Erythromycin.

8. Identify teaching and learning needs of the new mother and family of a newborn.

Be prepared to answer questions, verbally or by quiz, during the clinical day.

POSTPARTUM PREP FORM

1. Describe the physiologic and psychologic changes that occur in the postpartal period and the proper nursing assessment techniques utilized during the first 24 hours.
2. Discuss nursing interventions related to Pregnancy Induced Hypertension.
3. Define the terms: Fundus: Involution: Lochia:
4. Discuss the use of MMR vaccine and Rhogam.
5. Discuss care of the episiotomy site.
6. Discuss breast care for the lactating and non-lactating mother.
7. Describe the nurse's role in teaching and learning needs of the new mother and family and how early discharge effects this process.
8. Discuss the risk factors for postpartum complications and the nursing assessment needed to identify the factors and interventions to prevent them.
9. Discuss the TORCH diseases and identify the current protocols for prevention in the immediate postpartum period.

Be prepared to answer questions, verbally or by quiz, during the clinical day.

PREPARATION FOR LABOR PATIENT

To improve the student's learning experience when attending and caring for the first labor patient the following should be completed. The information should be written on additional pages.

1. Identify those characteristics which impact significantly on the client's expectations in labor.
2. Discuss physical and psych-social care needed by all patients in labor.
3. Complete asterisk* areas on Fetal Heart Monitor Strip Worksheet.
4. List normals in the following statistics:
 Blood pressure:
 Pulse:
 Fetal heart rate:
 Respirations:
5. Discuss symptoms which signify dangers to mother and/or infant and the pathophysiology.
6. Be able to define terms: Presentation, position, dilation, station, effacement, contraction, duration, frequency and intensity.
7. Discuss the effects of anesthesia and analgesia on the mother and infant.
8. Discuss pitocin for induction vs. use during the recovery period. Discuss Magnesium Sulfate for the pre-eclamptic pt vs. the preterm patient. Discuss assessment and risk factors for both pitocin (oxytocin) and magnesium sulfate.
9. Discuss the risks for pre-term labor, the current means for identifying patients at risk, and the identification and protocols for group B strep.

Be prepared to answer questions, verbally or by quiz, during the clinical day.

WORKSHEET FETAL HEART MONITOR STRIP
--

Patient Initials:	Date
<p>1. Fetal Heart Rate - Beats per minute? Check one of the following: Indicate criteria for all.</p> <p style="padding-left: 40px;"> <input type="checkbox"/> Tachycardia *Criteria: <input type="checkbox"/> Average *Criteria: <input type="checkbox"/> Bradycardia *Criteria: </p>	
<p>2. What is the baseline variability? What is the significance of reading? *</p> <p style="padding-left: 40px;"> <input type="checkbox"/> No variability: 0 to 2 bpm. <input type="checkbox"/> Minimal variability: 3 to 5 bpm. <input type="checkbox"/> Average: 6 to 10 bpm. <input type="checkbox"/> Moderate: 11 to 25 bpm. <input type="checkbox"/> Marked: greater than 25 bpm. </p>	
<p>3. Are there any periodic changes in the FHR?</p> <p style="padding-left: 40px;"> <input type="checkbox"/> Accelerations <input type="checkbox"/> Early deceleration -- Usual cause : * <input type="checkbox"/> Late deceleration -- Usual cause: * <input type="checkbox"/> Variable Deceleration -- Usual cause: * </p>	
<p>4. Looking at uterine contractions, determine the following: USE ADDITIONAL PAGES</p> <p style="padding-left: 40px;"> <input type="checkbox"/> Frequency: Define term: * <input type="checkbox"/> Duration: Define: * </p>	
<p>5. Nursing interventions utilized for all 3 types of decelerations. USE ADDITIONAL PAGES</p>	
<p>6. Summarize the significance of this strip. USE ADDITIONAL PAGES</p>	

*** Please complete the above noted areas prior to clinicals**

ASSESSMENT OF THE NEWBORN

Patient'S INITIALS:		DATE:
IDENTIFICATION PLACEMENT:		
DELIVERY DATE:	EDC:	APGAR: (1 m) (5 m)
METHOD OF DELIVERY:		Est. Gest. Age:
ITEM FINDING CLINICAL SIGNIFICANCE *		
Weight		
Length		
Posture		
Head Circumference		
Chest Circumference		
Temperature		
Resp:Rate & Effort		
Scarf sign		
Plantar creases		

*** Discuss normals and abnormal. Have this column prepared prior to nursery day.**

ASSESSMENT OF THE NEWBORN
(continued)

ITEM	FINDING	CLINICAL SIGNIFICANCE *
Square window		
Popliteal angle		
Recoil		
Skin: Color		
Birthmarks		
Lanugo		
Head Fontanelles Size/Shape		
Eyes		
Ears		
Genitals		
Reflexes: Grasp		

**ASSESSMENT OF THE NEWBORN
(continued)**

ITEM	FINDINGS	CLINICAL SIGNIFICANCE *
Sucking, rooting		
Tonic neck		
Moro		
Stepping		
<p>Perform a Ballard's Assessment for gestional age on newborn.</p> <p><u>Additional Comments:</u></p>		

SAME DAY SURGERY PREP SHEET

<p>1. Review Chapter 18, 19, 20 in Brunner & Suddarth</p>												
<p>2. Prepare drug cards for:</p> <table border="0"><tr><td>a. Alka Setzer Gold</td><td>d. Valium</td><td>g. Atropine</td></tr><tr><td>b. Zantac</td><td>e. Zofran</td><td>h. Chloral Hydrate</td></tr><tr><td>c. Versed Syrup</td><td>f. Reglan</td><td>i. Phenergan</td></tr><tr><td></td><td></td><td>j. Lovenox</td></tr></table>	a. Alka Setzer Gold	d. Valium	g. Atropine	b. Zantac	e. Zofran	h. Chloral Hydrate	c. Versed Syrup	f. Reglan	i. Phenergan			j. Lovenox
a. Alka Setzer Gold	d. Valium	g. Atropine										
b. Zantac	e. Zofran	h. Chloral Hydrate										
c. Versed Syrup	f. Reglan	i. Phenergan										
		j. Lovenox										
<p>3. Prepare a pre and postoperative teaching plan for a child undergoing a tonsillectomy. All interventions must have a referenced rationale. Information can be found in Brunner & Saddarth, London & Ladewig and on-line.</p>												
<p>4. Calculate the preoperative medication for a child weighing 22 lbs.</p> <p style="padding-left: 40px;">PAM 0.5 ml per kilogram available premixed in 10 ml syringe</p> <p style="padding-left: 40px;">Atropine 0.01 mg per kilogram available in 0.4 mg/ml vial</p>												
<p>5. Include discharge teaching for four patients in your log. The discharge teaching must have rationales that are referenced. <u>Briefly discuss procedure and patient history.</u></p>												
<p>6. Include a log for each day of clinical.</p>												

FAMILY CARE PLAN

PURPOSE: To learn to care for the family as a patient.

LOCATING FAMILY: The clinical instructor will assist the student to locate a suitable family.
Family members or friends will not be suitable.

NUMBER OF VISITS: The student will visit the family from 4 to 6 times.

WRITTEN REQUIREMENTS: The student will submit a written comprehensive care plan of 8-10 typed pages. The plan will include a written assessment, relevant diagnoses, outcomes, interventions, and evaluations with outcomes met or plans for different interventions. Diagnoses, outcome, and interventions should be referenced.

PROCESS: After deciding on the family to use for the family care plan, the student should:

- 1) Obtain a spiral notebook to keep a log of all activities related to the family care plan. Include all interactions with all health care team members, the family, and the clinical instructor. Included time devoted to all activities.
- 2) Review therapeutic communication techniques, interviewing techniques and view the VHS "Community Health and the Home Health Visit"
- 3) Contact the family approved by the clinical instructor to schedule the initial visit
- 4) Complete a "Family Visit Preparation Form" for the first and all other visits (may be included in the log).
- 5) Visit the family and complete the "Family Assessment Guide" – Due September 21 to faculty assigned to grade paper.
- 6) Determine the relevant diagnoses for each family member or family in general.
- 7) List the nursing interventions and/or teaching plans on the "Family Visit Preparation Form". These must include referenced rationales to support interventions.
- 8) Visit the family and initiate the interventions and/or teaching plan
- 9) Evaluate the effectiveness of the interventions and/or teaching plan
- 10) Continue steps 6, 7, 8 on subsequent visits
- 11) Terminate the relationship on the last visit insuring that the family knows ways to seek help in the future
- 12) Write the comprehensive care plan including the original diagnoses, outcomes, interventions with rationales and evaluations. Include any changes in diagnoses, etc. that were made as a result of the evaluations.
- 13) Submit your handwritten log, "Family Visit Preparation Forms", "Family Assessment Guide", and the type written comprehensive care plan (APA format) to your clinical instructor.
- 14) Meet with faculty advisor (frequency to be decided by advisor).
- 15) Submit two copies, grading sheet and copy of teaching materials to faculty assigned to grade your paper.

CRITERIA FOR EVALUATION

- 10% Introduction & Conclusion
- 10% Family Visit Preparation Forms & Log
- 20% Family Assessment Guide
- 10% Diagnoses and Outcomes
- 30% Interventions and Rationales
- 20% Evaluation and Adaptations

Arkansas Tech University
 Department of Nursing
 Family Care Plan - Level II

Student: _____ Grade: _____
 Instructor: _____

Introduction and Conclusion (10%)
Family Visit Preparation Forms and Log (10%)
Family Assessment Guide (20%)
Diagnoses and Outcomes (10%)
Interventions and Rationales (30%)
Evaluation and Adaptations (20%)
APA format, Grammar, Spelling As many as 5 points can be deducted

Criteria for Evaluation

Evaluation: (Total Possible Points - 100%)	POINTS
Introduction and Conclusion (10%)	___ points
Family Visit Preparation Forms and Log (10%)	___ points
Family Assessment Guide (20%)	___ points
Diagnoses and Outcomes (15%)	___ points
Interventions and Rationales(30%)	___ points
Evaluation and Adaptation (15%)	___ points
APA Format, Grammar and Spelling	
Total	___ points

FAMILY VISIT PREPARATION FORM

Visit # and Date	Evaluation/Response to Intervention	Plans for Future Visits (Date each entry)

FAMILY ASSESSMENT GUIDE
Adapted from Smith, C. & Maurer, F. Community Health Nursing

1. Identifying Data
Name _____ Phone _____
Address _____
Household members (relationship, sex age, occupation, education)
Financial data (income and sources, financial assistance, medical care plans, expenditures)
Religious and Cultural Health Implications (that includes three generations of family health/illness)
II. Individual Health Needs (may need to complete this section on several family members)
Identified health problems or concerns
Medical Diagnoses:
Recent surgery or hospitalization
Medications and immunizations
Physical Assessment Data
Emotional and cognitive functioning
Coping
Sources of medical care and dental care
Health screening practices
III. Interpersonal Needs
Identified subsystems (relationships)
Prenatal care needed
Parent -child interaction
Spousal relationships
Sibling relationships
Concerns about elders

Caring for dependent members
Significant others
IV. Family Needs
A. Developmental
Children and ages
Responsibilities for other members
Recent additions or loss of members
Other major normative transitions occurring now
Transitions that are out of sequence or delayed
Family proceeding at expected sequence
Tasks that need to be accomplished
Daily practices for nutrition, sleep, leisure, child care, hygiene, socialization, transmission of norms and values:
Family planning used
B. Loss or Illness
Non-normative events or illnesses
Reactions and perceptions of ability to cope
Coping behaviors used by individuals and family unit
Meaning to the family
Adjustments family has made
Roles and tasks being assumed by members
Any one individual bearing most of responsibility
Family idea of alternative behaviors available

Level of anxiety now and usually
C. Resources and Support
General level of resources and economic exchange with community
External sources of instrumental support (money, home aides, transportation, medicines, etc.)
Internal sources of instrumental support (available from family members)
External sources of affective support (emotional and social support, help with problem solving)
Internal sources of affective support (who in family is most helpful to whom)
Family more open or closed to outside sources
Family willing to use external sources of support
D. Environment
Type of dwelling
Number of rooms, bathrooms, stairs, refrigeration, cooking
Water and sewage
Sleeping arrangements
Types of jobs held by members
Exposure to hazardous conditions at job
Level of safety in neighborhood
Level of safety in household
Attitudes toward involvement in community
Compliance with rules and laws of society

How are values similar and different from immediate social environment
E. Internal Dynamics
Roles of family members clearly defined
Authority and decision-making rest where
Hierarchies, coalitions, and boundaries
Typical patterns of interaction
Communication including verbal and nonverbal
Expression of affection, anger, anxiety, support, etc.
Problem-solving style
Degree of cohesiveness and loyalty to family members
Conflict management
V. Analysis
What are the needs identified by family?
What are needs identified by family health nurse?

ARKANSAS TECH UNIVERSITY
 Department of Nursing
 Family Care Plan Agreement

NOTE: Agreement due to Assigned Faculty member on or before September 14, 2009.

Name of Student _____ Assigned Faculty Member _____

Name of Male Head of Household _____

Name of Female Head of Household _____

Street Address _____ Apt. No. _____

City, State, Zip Code _____

Telephone Numbers _____ Best Time to Call _____

In the table below, list the names of all persons living in this household, their ages, and relationship to the Head(s) of the household. If additional space is needed, use the back of this form.

Name of Each Individual Living in Household	Age	Relationship to Head(s) of Household

Head(s) of Household, please read the following statement and sign below:

I/We agree to allow the Arkansas Tech University Nursing Student named above to visit us in our home for the purpose of meeting his/her educational objectives in the Nursing Program at Arkansas Tech University. We understand that the student will be interviewing us and may carry out teaching programs and/or other nursing actions provided that we give consent. We understand that the information we provide the student will be kept confidential and will be handled in a professional manner. We understand that we may refuse any teaching or other nursing care at any time. We understand that the student will be visiting us in our home from four to six times over the period of the next several weeks. We understand that this agreement will be terminated the last scheduled visit. whichever comes first.

I/We agree to the above statement _____ Date _____

I agree to the above statement _____ (Student) Date _____