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Cerebral palsy supportive care Comfort & daily function

Child Health Nursing | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

8-year-old girl with caregiver present. Care stage: During supported recovery and essential daily activity.

Medical history: Cerebral palsy was diagnosed in early childhood. The child uses individualized rehabilitation and communication support; current swallowing and daily-care needs are reviewed with the caregiver. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: A caregiver is available for teaching and assisted care. The family requests plain-language instructions, a practical feeding/activity plan and follow-up. Assess development, immunization record and safeguarding individually.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Difficulty with movement, daily care and tiring during meals.

Objective findings and required checks: Motor impairment and support needs; assess communication, swallowing, skin and growth individually.

Physical examination and investigations: Review functional abilities, swallowing, nutrition, communication and rehabilitation assessments.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Cerebral palsy supportive care: Early non-progressive brain injury affects motor control; associated needs vary widely.

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Medical / surgical management

Provide individualized positioning, mobility aids, communication support and a safe feeding/self-care plan.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antispasticity medicine	Manage selected troublesome muscle tone	Monitor sedation, weakness and functional effect
prescribed other therapy	Treat identified associated conditions	Verify the individualized specialist plan.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Difficulty with movement, daily care and tiring during meals. Motor impairment and support needs; assess communication, swallowing, skin and growth individually. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize movement limited by weakness, discomfort or restriction; daily self-care needs exceed current ability; difficulty swallowing with possible aspiration; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Provide individualized positioning, mobility aids, communication support and a safe feeding/self-care plan. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met

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using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration. 4. Provide individualized positioning, mobility aids, communication support and a safe feeding/self-care plan. Rationale: Early non-progressive brain injury affects motor control; associated needs vary widely. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about coughing with meals, choking and voice changes. Assess: Observe secretion handling and follow a validated swallowing-screen pathway.	Difficulty swallowing with possible aspiration. Possible factors: impaired swallowing coordination or reduced airway protection. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Airway remains protected while an appropriate feeding plan is established. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver follows the assessed swallowing and feeding plan.	1. Withhold oral intake when safety is uncertain and request the appropriate swallowing assessment. Rationale: Unassessed oral intake may cause aspiration. 2. Use only the assessed posture, texture and assistance plan. Rationale: Individual recommendations improve swallowing safety. 3. Maintain oral care and monitor respiratory changes. Rationale: Oral hygiene and early recognition reduce consequences of aspiration.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach safe handling, aids, feeding plan and accessible participation in school and daily activities. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach safe handling, aids, feeding plan and accessible participation in school and daily activities.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

New swallowing/respiratory difficulty, seizures, pain or sudden loss of function needs review rather than attribution to the diagnosis alone.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Early non-progressive brain injury affects motor control; associated needs vary widely.

- Priority concerns: Movement limited by weakness, discomfort or restriction; Daily self-care needs exceed current ability; Difficulty swallowing with possible aspiration; Learning needs about the condition and care plan.

- New swallowing/respiratory difficulty, seizures, pain or sudden loss of function needs review rather than attribution to the diagnosis alone.

- Teach safe handling, aids, feeding plan and accessible participation in school and daily activities.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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