HEARTLAND REGIONAL GENETICS NETWORK

UNIVERSITY OF SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE
Center for Disabilities

Healthcare Plan Toolkit:
Healthcare Plan Development for School Nurses

General Guidelines

- Consult and follow state laws and school district policies
- Healthcare plans should be typed using the healthcare plan template provided.
- Utilize nursing care plan books in development of the healthcare plan.
- Healthcare plans should be saved electronically.
- Healthcare plans should include student demographic information, health condition, nursing diagnosis, expected outcome, assessment/symptoms, plan (interventions and accommodations), evaluation, additional comments if any.
- Nurses may choose to create lists of commonly used nursing care plan information (ADOPIE) to use as a reference for creating healthcare plans.

Parent Meeting

- It is beneficial if the nurse can first meet with parents and gather medical documentation to learn about the student's specific condition and needs, so that the healthcare plan can be individualized to the student. The care plan can be developed at the meeting with the parent, or can be developed after the meeting and then shared with the parents.

Demographic Information

- Fill in all demographic information including student name, date of birth, parent's name, and physician's name. Insert student's picture in picture box.

Health Condition/Nursing Diagnosis

- Fill in the student's health condition as identified by medical documentation. Nurses are not able to medically diagnose a student. The nurse can however identify an appropriate nursing diagnosis. A nursing diagnosis should be chosen from the North American Nursing Diagnosis Association (NANDA) approved list.

Outcomes

- Be cognizant of how the expected goal or outcome is written. Ensure that outcomes are realistic and appropriate for the student. Avoid language such as "student will be free of asthma attacks 100% of the time" or "student will be free from respiratory distress". NANDA provides suggested outcomes which may be appropriate to use.

Assessment/Symptoms

- When writing assessment/symptoms the nurse should use information such as medical documentation, physician input, and parent input to capture the student's specific individual symptoms. Often times certain diagnosis have similar symptoms, but each student can present slightly different. A comprehensive specific list of symptoms should be included.

Plan/Interventions

- Healthcare plan accommodations and interventions should be individualized to the student using information such as medical documentation, physician input, and parent input.
- Accommodations/interventions should be written clearly, concisely and should be easy for staff to read and understand. A staff member should be identified as responsible for each accommodation/intervention.
- Accommodations/interventions should allow for the maximum independence appropriate for the student.
- Consider writing "medication will be administered as ordered by the physician- see current physician order" instead of the medication name, dosage etc. Medications may change frequently. The plan should guide staff to the medication administration record (MAR) and the doctor's orders so that they have the most current accurate medication order.

Evaluation

- The evaluation should include ways in which the nurse can assess that the plan is being effectively implemented.
- The evaluation may include the date that staff were trained on the healthcare plan.

Additional Comments

- In this space provide any additional important information that staff may need to know about the student.
- Mark if the plan is attached to the student's IEP or 504 plan.