Personal Organizational Plan

Name: **Shyam Nath Pandey**

Centennial College

Placement Facility: Birchmount - Cardiac 3D

Clinical Instructor: Lecia Mckenzie

Date: 02/20/2026

PERSONAL ORGANIZATIONAL PLAN (POP)
Students complete a POP for each new client and update existing POP's weekly

STUDENT: Shyam Nath Pandey WK# 5 DATE: 02/13/2026

CARE PARTNER: NURSING SUPERVISOR: Mikida Feli

LEVEL OF CARE

Code	Patient's/resident's/client's self-evaluation
0	Independent-Able to accomplish all ADLs without intervention from staff or family: bathe, dress, groom, transfer and ambulate, toilet, communicate
1	Minimal Assist- Walks/transfers independently; infrequent falls –verbal reminders.
2	Stand-By Assist-Transfer/stand-by assist may be needed. ADLs – reminders, verbal cues. Occasional incontinence assistance. Bathing set-up helpful.
3	Hands-On-Transfer-one person assist usually needed. ADLs – verbal cues to hands-on assist. Incontinence mgmt. Bathing assistance needed.
4	Total Assist-Transfer-mechanical lift/two-person transfer/bedfast. ADLs-hands-on assistance. Incontinence mgmt. Bathing assistance.

Client No. (Initial & Room No.	Health Problem / Diagnosis	Level of Care
1.G.A (3414-01)	Generalized weakness	3
2 W. e. (3415-02)	Pleural effusion	0
3 W.C.O (3417-01)	CHF exacerbation	0
4J.B.D (3417-02)	Pulmonary embolism	4

TIME	PLANS/ACTIVITIES TO MEET THE CLIENT NEEDS	OBSERVATIONS TO REPORT AND CHART
0630	Arrived at facility and changed uniform	N/A
0700	Meet clinical instructor in main lobby, attend pre-conference meeting and assigned the patient bed 3414-01 and 3415-02 and Nurse	N/A
0730	Find nurse and getting detail information about assign patient by nurse.	Introduced to assigned nurse. Get information about assign patient.
0745	Go to the assign patient room and check patient condition	Patients were sleeping and breathing well.
0800	Entered room 3415-02 with nurse, introduce with patient and assist taking vital sign.	Patient was wakening up, assist nurse to take vitals. T-36.9, P- 85, R-18, BP-126/58, SPO2-95
0815	Entered room 3414-01, introduce myself and setup breakfast.	Patient was independent. She sited on chair and ate.
0825	Assisted patient (room 3415-02) for feeding.	Patient was fully dependent, helped for feeding and she is on plural diet. She ate 2-3 scope and refused. Report to the nurse.
0850	Assisted nurse to pull up the patient room 3417-01	Patient was in O2 therapy, fixed oxygen marks properly and put her head up.
0900	Assisted patient to walk with walker.	Observed patient walking with walker. She walked around 10 meters on hallway.

0925	Assisted patient to give the water from the pantry room.	N/A
0935	Again, assisted patient (room 3415-02) for feeding.	Patient ate 125ml orange juice, 50 ml chocolate milk, and 100 ml thicken water. Report to the nurse.
0950	Helped to the other member 3410-01, assist with patient transfer to another bed for going to X-ray room.	Patient and other team member appreciated to me.
1030	Full bed bath provided to 3415-02(peri care, brief change, gown change, making occupied bed	Observed skin condition no redness and swelling, large bowel movement, brief was not heavy that means small amount of urine collection, yellow colour, report to the nurse.
1100	Break	N/A
1135	Cleared patient's breakfast tray Room # 3414-01	N/A
1140	Helped to the nurse for pulled up patient (3415-01)	N/A
1150	Setup lunch tray to the patient room 3414-01	Patient was independent.
1200	Replaced supplies in room # 3409-04	N/A
1210	Helped to the other member 3410-01, assist with boost up and reposition	N/A
1220	Checked cline chart on computer	N/A
1250	Clear patient's lunch tray	Patient finished and full of breakfast. Reported to the nurse
1300	Assisted discharge patient to transfer bed to another bed.	N/A

1315	Clear patient's lunch tray	Report to the nurse that patient ate less than 30%
1330	Lunch Break	N/A
1400	Returned from break. Conducted safety round and checked brief and asked if they need any help.	Boost up the patient, patient appreciated our help and look happy.
1415	Work on the computer	N/A
1430	Post conference	N/A
1500	Leaved from facility	N/A

Data Sheet for Each Client

GUIDE – RESIDENT/CLIENT INFORMATION AND NEEDS

The Information can be gathered from the patient/resident/client, family, Care Partner, Faculty Instructor

AGE: **72 years** STAGE OF GROWTH & DEVELOPMENT: **Late Adulthood**

BIRTHPLACE: **Information not available**

ETHNIC/CULTURAL BACKGROUND: **Armenian**

CULTURAL/RELIGIOUS: PRACTICES/OBSERVANCES: **Information not available**

PREVIOUS LIVING ARRANGEMENTS: **Information not available**

PREVIOUS OCCUPATIONS/ROLES: **Information not available**

FAMILY MEMBERS/FRIENDS/VISITORS: **Family members' visit**

REASON/S FOR BEING IN FACILITY: **General weakness**

LENGTH OF TIME IN FACILITY: **Feburary14, 2026 (5 days)**

ABILITY TO SEE/HEAR/SENSE OF TOUCH/TASTE/SMELL:

He can see/hear/sense of touch/ taste/smell

ABILITY TO COMMUNICATE/DEVICES/APPROACH:

He understands English, she can communicate with health team

AWARENESS OF SURROUNDINGS/PLACE/OTHER PERSONS/SAFETY:

Patient is aware of surroundings, visually recognizes me in the following days, is aware of personal safety when moving in the bed and moving from bed to washroom.

PRESENT FEELINGS & CONCERNS:

The client is generally calm and collected He looks tired. She is appreciative of receiving assistance and service.

RE: SELF/CONDITION/PLACEMENT/FAMILY/ACTIVITIES/LIFE/COMMUNITY/ etc.

Before coming hospital, patient was living at long term care.

OVERALL APPEARANCE & ABILITIES/LIMITATIONS TO FUNCTION:

She looks tired, weak and drowsy need assistant 1 person.

SPECIFIC NEEDS OF THE CLIENT

1. SAFETY NEEDS (PRECAUTIONS/ASSISTIVE DEVICES) (Specific/when, where, how):

Maintain the bed in its lowest position with the call bell at hand to avert falls since the client is weak, and he needs a one-person support to transfer. It is necessary to ensure that ambulation is done under supervision with the use of a walker, which is applicable to the accident prevention

and safety of equipment as outlined in Chapter 22. In case of any weakness or dizziness, report the same to the nurse.

2, MOBILITY/POSITIONING /EXERCISE/ AND REST (Including assistive devices/wheelchair/lifting/transfer/ambulation/repositioning/active ROM):

Helping with mobility with the help of a walker and one-person support, promoting frequent activity as possible and referring to the care plan. Enhance accurate positioning and mobilized ROM to fight the risks of low mobility such as constipation or skin complications, according to body mechanics chapters. Rest and activity alternates to overcome fatigue, and do not overwork.

3. HYGIENE: SKIN CARE - REPOSITIONING/CARE TO PRESSURE AREAS:

(Observations-abnormalities/ frequency, type, positioning aids, appearance of all pressure areas, care to pressure areas/skin protective care):

The client is at risk for skin breakdown due to reduced mobility and advanced age. Patient requires assistance with full morning hygiene, perineal care, and regular reposition. We must reposition every 2 hourly. No open areas are present, but close monitoring of pressure areas is necessary.

4. FOODS/FLUIDS/DIET/SPECIAL DIET/SNACKS/USUAL INTAKE PATTERN/APPETITE (Ability to swallow-solids/liquids/ methods of assistance/positioning/cultural needs preferences/frequency/amount/type of fluids/preferences; intake & output measurement)

Adhere to heart-healthy, diabetic, no-caffeine diet; establish on your own, as much as possible, keeping track of intake to propel energy against weakness. Consult with dietitian, encourage balanced diet, per nutrition chapters, special diets and swallowing safety.

5. NEED FOR COMFORT (Relief of pain/discomfort/distress/comfort measures):

Patient complains of leg pain. Used extra pillows for re-positioning, provided quiet period

PSW Role for Safety Needs Identify:

- ***Turn and re-position ever 2 hours for comfort.***

- ***Observe any sign of pain and discomfort and report pain to the assigned nurse.***

6. NEED FOR AIR/BREATHING/OXYGEN: TPR (Previous range/present/ shortness of breath/cough - observations; colour face lips/nails/feet: - colour & temperature/edema /positioning e.g. extremities; positions for breathing;/ oxygen safety precautions/sputum specimen):

She doesn't have any issues of breathing.

7. ELIMINATION NEEDS-URINARY ELIMINATION PATTERN: frequency, observations- amount; colour; odour; clarity; incontinence; assistance/what used to encourage/place/devices - catheter, etc. Urine specimen/Diabetic Urine testing):

Patient is using brief for elimination. We must observe urine colour, amount, odour and its characteristics. Report any change in urine characteristics to the assigned nurse.

8. ELIMINATION NEEDS-BOWEL ELIMINATION PATTERN: frequency, observations - amount; colour; consistency; other/incontinence/assistance/ place/ devices - ostomy; specimens): Observation of bowel habit reduced mobility, increase the risk of constipation.

I did not observe the patient having a bowel movement while providing care. I will continue to provide perineal care as needed and monitor stool frequency, color, consistency, and amount. Any signs of constipation, diarrhea, or changes in bowel pattern will be promptly reported to the assigned nurse to ensure the patient's safety and comfort.

9. REHABILITATION/SOCIAL INTERACTION/LEISURE & STIMULATION NEEDS/INTERESTS/PRACTICES-NEEDS FOR EMOTIONAL SUPPORT

(Identify feelings/ moods/motivation/coping methods/goals/self-concept/adjustment to changes/and specific type of supportive/communication /assistance required):

The patient shows limited interaction and may require gentle verbal cues and reassurance. I will provide emotional support as needed and observe for any changes in mood, responsiveness, or behavior, and promptly report any concerns to the assigned nurse.

10. ADDITIONAL TREATMENTS/SUPPORT ACTIVITIES (WITHIN PSW ROLE) FOR CLIENT:

Encourage to the patient for doing her regular exercise and proper balance diet consulting with dietician.

Reference

Sorrentino, S.A., Remmert,L., Wilk, M.J., Newmaster, R. (2013). *Mosby Canadian textbook for the support worker* (3rd Canadian ed.). Toronto: Elsevier