

QUINSIGAMOND COMMUNITY COLLEGE

NURSE EDUCATION PROGRAM

NURSING CARE PLAN GUIDE

ADULT CARE

**Please use this format on other sheets of paper.*

Student name: _____ Date(s) of care: _____

1. GENERAL INFORMATION/NURSING DATA BASE

**This section provides basic demographic data. All questions must be answered. If you did not obtain the data, you must state why. When you are completed, there should not be any empty spaces.*

Age: _____ Gender: _____ Marital Status: _____ Code Status: _____

Occupation/work status: _____

Admitted from: Home LTC facility Other (specify) _____

Admitting Diagnosis: _____ Date of Admission _____

Surgery this admission: _____ Date of surgery _____

Change in admitting diagnosis: _____

Allergies: _____ Health Care Proxy: _____

*(*A change in the admitting diagnosis may have occurred due to either diagnostic tests or surgery performed. For example, your patient may have been admitted with a “rule out cholelithiasis”. After admission, diagnostic studies may have been performed and ruled in this diagnosis and thus, 1.6 Change in admitting diagnosis would state, “cholelithiasis” and state the date the diagnosis was made.)*

2. OUTLINE OF HEALTH HISTORY - *These questions must be answered completely and thoroughly.

- A. History of the present illness/ What brought patient to seek medical attention
*(*This is the patient’s chief complaint in the patient’s own words. Give a history of the patient’s symptoms, including any interventions that may have been utilized by the patient prior to admission.)*
- B. Define the admitting diagnosis using the **course textbook**.
- C. Explain the pathophysiology of the disease process, including the signs and symptoms. (Cite source)
- D. **Compare and contrast** the client’s signs and symptoms to the **textbook** description.
- E. List all chronic/pre-existing medical and psychological diagnoses. Briefly define each diagnosis, including the signs and symptoms.
- F. List all medications the patient takes at home and correlate to the disease process if applicable.
(Include any OTC, herbal remedies, and prescription medications patient took prior to admission)
- G. List all past surgeries, briefly define each surgery with the patient’s outcome. If applicable, relate previous conditions to this hospitalization’s admitting diagnosis.

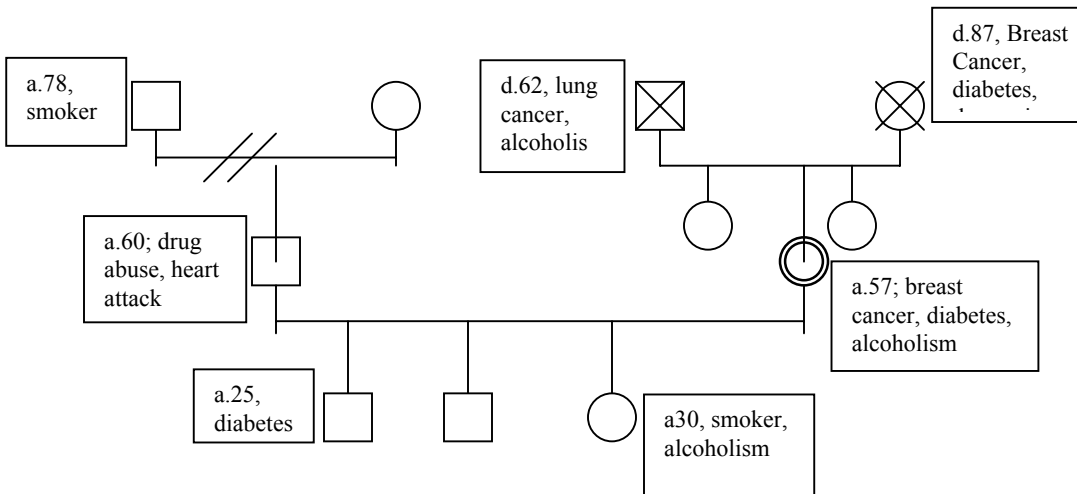
H. Outline of the family history of the **patient's parents, grandparents and siblings and children**. Construct a family tree to demonstrate the age and health or the age and cause of death of blood relatives. (*Specifically ask for any family history of heart disease, high blood pressure, stroke, diabetes, blood disorders, cancer (type of cancer) , sickle cell anemia, arthritis, alcoholism, mental illness, seizure disorder, kidney disease and tuberculosis.*)

KEY:

Male = □ ; Female = ○ ; patient = ◻ or ◉ ; ⊠ = Death (male)



EXAMPLE:



HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. Identify if the problem warrants collaboration with other departments to meet the client needs.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3. B UNIVERSAL REQUISITE: AIR

ASSESSMENT DATA:

The assessment data should include all information related to the client's oxygenation. Some example of information to include are: lung sounds, use of oxygen ,history of smoking, cough, dyspnea, O2 saturation, pulses and capillary refill.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

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NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3.C UNIVERSAL REQUISITE: WATER

ASSESSMENT DATA:

Assessment data should include evaluations of client's skin turgor, mucous membranes, intake and output, presence of edema, intravenous, oral and gastric tube intake or output, as well as significant diagnostic tests.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. Identify if the problem warrants collaboration with other departments to meet the client needs.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3.D UNIVERSAL REQUISITE: FOOD

ASSESSMENT DATA:

Assessment data should describe client's food intake. Elicit and document information about your client's process of ingestion(chewing, swallowing), digestion, absorption, transport and metabolism. How is the client's nutritional/caloric intake. Is the client able to feed him/her self?

or

Has there been weight gain, weight loss (BMI) and/or change in energy level. Are there symptoms of nausea, gas,

Pain, determine and document how these symptoms being addressed. Elicit and document information about your client's knowledge of nutrition and how nutrition relates to their well-being.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. Identify if the problem warrants collaboration with other departments to meet the client needs.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3.E. UNIVERSAL REQUISITE: ELIMINATION

ASSESSMENT DATA:

1. **Bowel/Emesis**
Include information related to routine bowel habits, aides for constipation, understanding of proper food and fluid intake as well as abdominal assessment.
2. **Urination**
*Include information related to urination, pain with urination, frequency, dribbling, color, amount and aroma of excretions and secretions.
If collection devices such as urinary catheter is being used, assess and document your client's understanding and knowledge of why the device is being utilized and how to care for it.*
3. **Skin Integrity**
Assess and document the condition, and color of your client's skin, noting any abnormalities such as discolorations, presence of lesions rashes, and other breaks in integrity.
4. **Wound Assessment**
Utilize REEDA method to evaluate wound. Note drainage ,type, amount, odor, condition of surrounding skin and wound bed.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. Identify if the problem warrants collaboration with other departments to meet the client needs.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3. F UNIVERSAL REQUISITE: ACTIVITY/ REST/ SLEEP

ASSESSMENT DATA:

The assessment data here describes the patient's usual pattern of exercise and activity including the ability to perform activities of daily living and to participate in leisure and recreational activities. Elicit and document information about the patient's desire, choice and actual involvement in self care, work, exercise and leisure activities.

Determine and document if and how the patient's present condition has interfered with the ability to perform these activities and how activity/mobility needs are being met.

Has the patient's present condition produced symptoms such as chest pain, dyspnea, claudication, fatigue, weakness or musculoskeletal pain? Determine and document how these symptoms are being addressed.

If assistive devices are being used, assess and document your patient's knowledge of why the device is being used and how to safely use it.

The assessment data here describes the patient's usual pattern of sleep, rest and relaxation. Elicit and document information about the patient's perception of the effectiveness of his/her sleep and relaxation methods as well as any routines or activities used to promote sleep.

Determine and document if and how the patient's present condition has interfered with the ability to sleep and/or relax.

If the patient's present condition has produced symptoms that cause an inability to sleep or if the environment interferes with the ability to sleep, determine and document how these symptoms are being addressed.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. Identify if the problem warrants collaboration with other departments to meet the client needs.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3.G UNIVERSAL REQUISITE: SOLITUDE/ ISOLATION

ASSESSMENT DATA:

The assessment data here describes the roles and relationships of the patient and examines the patient's self evaluation of his/her performance related to these roles. Elicit and document information about your patient's role and responsibility at work, in the family or in the community (social life). (CONTINUE)

Ask the patient to describe his/her family, social and work relationships to determine if these relationships are satisfying or troubling to the patient and to evaluate the effect the present condition has on your patient's role and relationships.

The assessment data here describes the patient's satisfaction, dissatisfaction or dysfunction with personal sexuality and describes the reproductive pattern. Elicit and document information about your patient's sexual and reproductive concerns.

Determine and document if and how the patient's present condition has affected sexual function or if there is a lack of knowledge relative to sexuality and/or reproduction.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. If the problem warrants collaboration with other departments to meet the client's needs after discharge.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3.H UNIVERSAL REQ: PREVENTION OF HAZARDS TO LIFE FUNCTION AND WELL-BEING

ASSESSMENT DATA:

Describe client's perceptions of his/her own health and well-being and describe how the client's health is managed, Describe his/her participation in health seeking practices (i.e. preventative screening, immunizations, nutrition and Exercise, etc.)

Elicit and document information about your client's knowledge of: (1) the health problem, (2) awareness of what should be done and (3) the ability to use appropriate resources to manage the problem.

Describe the medical treatment recommendations, medications and/ or regimes he/she complies with to maintain or improve health.

The assessment data here describes the patient's ability to see, hear, taste, touch and smell as well as the ability to communicate, understand, remember and make decisions regarding his/her own life choices.

Elicit and document information about your patient's senses and cognitive ability as they relate to his/her ability to perform activities of daily living.

Questions regarding sensory deficits and the way your patient compensates for these deficits should be asked and noted.

Determine and document if and how the patient's present condition has interfered with the senses or cognition and how sensory-perceptual needs are being met.

If the patient's present condition has produced sensory deficits or symptoms such as memory loss, determine and document how these deficits are being compensated for and/or how the patient is being protected from harm.

Identify any high risk behaviors/ habits that the client might present with such as unsafe sex, Etoh and/or drug

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

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NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

4. DEVELOPMENTAL ASSESSMENT:

4.A Identify the developmental stage (according to Erikson) for this client's age group. Explain the behaviors that relate to the tasks of this stage.

4.B State the developmental level you perceive your client to be functioning at and substantiate your assessment. If applicable, substantiation should address what significance the current illness has on the stage of development.

5. DIAGNOSTIC ASSESSMENT/ANALYSIS GUIDE

Record all admission and most current diagnostic tests. Please utilize the form provided in the addendum section of this care plan.

* *Diagnostic tests performed to assist in the determination of a medical diagnosis includes: blood work, x-rays, specimen cultures, scans, EKG's etc.*

| LABORATORY TEST | ADMISSION TEST RESULTS | SUBSEQUENT TEST RESULTS (include date of test) | NORMAL LAB VALUE ACCORDING TO SEX & AGE | INTERPRETATION OF TEST RESULTS |
|--|---|---|---|--|
| <p><i>1. List each diagnostic test including both normal and abnormal results.</i></p> | <p><i>1. Document the date the test was performed and your patient's results.</i></p> | <p><i>1. Document the date the test was performed and your patient's results.</i></p> | <p><i>1. Document the normal lab value according to the sex and age of the patient listed in your current laboratory and diagnostic textbook.</i></p> | <p><i>1. Begin the interpretation by stating if the results are normal or abnormal. If abnormal, state how the result is abnormal (high, low, irregular, etc.) and compare the two test results.</i></p> <p><i>2. State why the result is abnormal for <u>your</u> patient. Relate the result to your patient's medical diagnoses.</i></p> <p><i>3. State what interventions are currently being performed to correct the abnormality. State whether or not the intervention is effective as evidenced by a change in value.</i></p> <p><i>For example: Hgb=8 gm on 9/2/04. This result is low, due to surgical blood loss during hip replacement surgery. The patient received 1 unit of packed RBC's on 9/3/04 and is currently receiving FsSo4 325 mg po dly.</i></p> |

5. DIAGNOSTIC ASSESSMENT/ANALYSIS

Record all admission and most current lab data in the sections provided below. **Laboratory data includes diagnostic tests performed to assist in the determination of a medical diagnosis. Laboratory data includes blood work, x-rays, specimen cultures, scans, EKG's etc.*

| <u>Lab test</u> | Admission test results | Subsequent test results (include date of test) | Normal lab value according to sex & age | Interpretation of test results |
|------------------------|-------------------------------|---|--|---------------------------------------|
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6. ORDERED PATIENT MEDICATIONS:

Please list all medications ordered by the physician that your patient is currently receiving.

| MEDICATION ORDER | CLASS | ACTION | INDICATION SPECIFIC TO YOUR PATIENT | SIDE EFFECTS | NURSING IMPLICATIONS |
|-------------------------|--------------|---------------|--|---------------------|-----------------------------|
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ADULT MEDICAL-SURGICAL--PLANNING, INTERVENTION AND EVALUATION

State the universal requisite according to OREM (Air, Water, Food, Elimination, Activity/Rest, solitude/social isolation, prevention of hazards and promotion of normalcy) Using the data collection, prioritize the nursing diagnosis. Priority indicates your perception of the order of importance in which you would deliver care.

Develop the care plan for the three priority nursing diagnosis

- **ASSESSMENT**
- **NURSING DIAGNOSIS**
- **OUTCOME CRITERIA**

Assessment data:

a. Subjective data

A verbal statement made by the client or from a secondary source such as family that supports the nursing diagnosis.

b. Objective data

Data collected from physical assessment, medical record, nursing kardex, critical paths that supports/validates the nursing diagnosis. Example of data includes: medical diagnosis, surgical procedure, medications, lab values, vital signs, presence of tubes (NG, G-tube, Jackson Pratt, hemovac, J-vac, foley catheter), wounds, IV sites, TPN, Pain scale, etc.)

c. Nursing Diagnosis

A statement which identifies an actual health problem or the risk of a health problem development (term used “High risk for”). The nursing diagnosis should requisite.

d. Outcome criteria (*expected patient outcomes*)

Are behavioral statements written in objective and measurable terms, specifically for the patient that corresponds with the nursing diagnosis. Outcomes are the desirable health states that the patient wants to achieve by progressing towards the resolution or modification of an actual problem or that prevents a condition. “The patient will”.

NURSING INTERVENTIONS

List the specific nursing actions that you would perform to assist the client with achieving the desired patient outcomes. Interventions should be patient specific and coordinate with the objective data.

Nursing interventions must be written in an organized fashion (**Assess, monitor, administer, perform, teach**) with time frames (q shift, q 4 hours, etc).

Interventions related to medication administration must include the medication order, the nursing implications if applicable, and any teaching that would be necessary.

***Each intervention must be followed with the text referenced for the information.**

RATIONALE

For each nursing intervention, state the physiological and/or psychological scientific principles that provide foundation for nursing interventions. Rationales answer the questions why, how and what. When applicable, rationales should be patient specific and should coordinate with the nursing diagnosis being addressed.

For example, if the nursing diagnosis is Acute pain and one of your interventions is to assess vital signs every 4 hours, the rationale should include what changes occur with the vital signs when acute pain is present.

Rationales related to medication administration must state the class, action and indication for use. Indications must be patient specific and should coordinate with the objective data.

***Each rationale must be followed with the text referenced for the information.**

EVALUATION

The evaluation phase of the nursing process is performed to determine whether progress toward the achievement of the expected patient outcomes is being made.

Give specific evidence of progress being made

If progress is being made, a statement should indicate to continue with the plan.

If progress is not being made, a statement should be made as to what changes in the plan or in the criteria itself would be made.

Revised 8/04