

**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.**

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. )*

3. ASSESSMENT/UNIVERSAL REQUISITES

HEALTH ASSESSMENT

Health history given by:            Patient            Other: (state relationship)\_\_\_\_\_

<u>VITAL SIGNS</u>	<u>ASSESSMENT NOTE/DATA</u>
<i>*on the day you cared for your patient</i> T: _____ PO PR AX TM P: _____ Radial Apical R: _____ Regular Irregula B.P: _____ Left Right Height _____ Weight Pain level _____ Type _____ Location _____	<i>*This is your assessment note you wrote on the day you cared for your patient.</i>

**\*\*Incorporate any abnormal assessment data into appropriate Universal Requisite**

3. A UNIVERSAL REQUISITE: PROMOTION OF NORMALCY

ASSESSMENT DATA:

1. Coping/ Stress:

2. Self Perception/ Self Concept:

3. Value-beliefs

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

NURSING DIAGNOSIS:

3. B UNIVERSAL REQUISITE: AIR

ASSESSMENT DATA:

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

NURSING DIAGNOSIS:

3.C UNIVERSAL REQUISITE: WATER

ASSESSMENT DATA:

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

NURSING DIAGNOSIS:

**3.D UNIVERSAL REQUISITE: FOOD**

**ASSESSMENT DATA:**

**HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:**

**NURSING DIAGNOSIS:**

**3.E. UNIVERSAL REQUISITE: ELIMINATION**

**ASSESSMENT DATA:**

1. **Bowel/Emesis**

2. **Urination**

3. **Skin Integrity**

4. **Wound Assessment**

**HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:**

**NURSING DIAGNOSIS:**

3. F UNIVERSAL REQUISITE: ACTIVITY/ REST/ SLEEP

ASSESSMENT DATA:

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

NURSING DIAGNOSIS:

**3.G UNIVERSAL REQUISITE: SOLITUDE/ ISOLATION**

**ASSESSMENT DATA:**

**HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:**

**NURSING DIAGNOSIS:**

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

**ASSESSMENT DATA:**

**HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:**

**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.*

<b><u>Lab test</u></b>	<b>Admission test results</b>	<b>Subsequent test results (include date of test)</b>	<b>Normal lab value according to sex &amp; age</b>	<b>Interpretation of test results</b>

**6. ORDERED PATIENT MEDICATIONS:**

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

<b>MEDICATION ORDER</b>	<b>CLASS</b>	<b>ACTION</b>	<b>INDICATION SPECIFIC TO YOUR PATIENT</b>	<b>SIDE EFFECTS</b>	<b>NURSING IMPLICATIONS</b>

