

# DAILY CARE PLAN

by Barbara Karnes, RN

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Date: \_\_\_\_\_

Water Intake: \_\_\_\_\_ ounces

## Food Intake

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snack: \_\_\_\_\_

## Protein Supplements (8 ounce cans)

1      2      3      4

Peed 1      2      3      4

5      6      7      8      9

## Catheter Bag Emptied

Time: \_\_\_\_\_ How much: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Bowels      1      2      3      4

Comments: \_\_\_\_\_  
\_\_\_\_\_

Mental Status:      Alert      Confused

Comments: \_\_\_\_\_  
\_\_\_\_\_

Emotional Status:      Quiet      Withdrawn

Comments: \_\_\_\_\_  
\_\_\_\_\_

I smiled today because \_\_\_\_\_  
\_\_\_\_\_

I am thankful for \_\_\_\_\_  
\_\_\_\_\_

Activity:      Up/About \_\_\_\_\_

In Chair \_\_\_\_\_

In Bed \_\_\_\_\_

Sleeping:      During the Night \_\_\_\_\_

Naps \_\_\_\_\_

Sleep Quality \_\_\_\_\_

## PAIN ASSESSMENT      Yes      No

If yes, rate a scale of 1-10: \_\_\_\_\_

Time of last pain medication \_\_\_\_\_

In 45 minutes, was there comfort?      Yes      No

Pain number then?      Yes      No

Additional Instructions to Plan of Care: \_\_\_\_\_  
\_\_\_\_\_

Questions for Nurse, Social Worker, Chaplain,  
Home Health Aide? \_\_\_\_\_  
\_\_\_\_\_

Comments About the Day: \_\_\_\_\_  
\_\_\_\_\_

Today I did this just for me: \_\_\_\_\_  
\_\_\_\_\_

## MEDICATIONS

Medication	Times to Give
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____