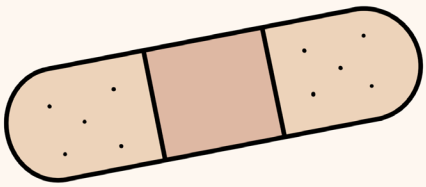
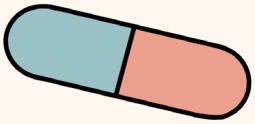
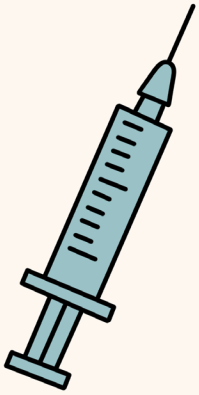
NURSE IN THE MAKING

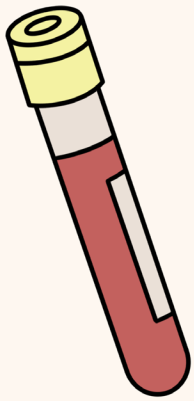




NURSE IN THE MAKING

CLINICAL *Care Plan* GUIDE





WHAT IS A NURSING CARE PLAN?

You may think: *"Why are we doing this if the nurse on the floor doesn't do this?"*

Well, this isn't totally true, the computer at your hospital may autogenerate care plans based on the diagnosis. Although, they may not be as detailed as seen in nursing school.

The purpose of them is to train your brain to think, plan, and evaluate like a nurse. This is a learned skill, and care plans help with this.

These are helpful tools to prepare you & your thought processes!

A nursing care plan IS:

- ✓ A useful tool to identify and prioritize problems for each patient
- ✓ A "start-to-finish" outline of an identified problem and how to approach it
- ✓ Patient-centered & individualized
- ✓ Fluent & flexible
  - Should change with patient's needs & evaluations
- ✓ Based on clinical judgment
- ✓ Based on the Nursing Process

A nursing care plan IS NOT:

- ✗ A clinical or medical diagnosis
- ✗ A "one-size-fits-all" outline
- ✗ A definitive diagnosis (set in stone)

Why are we choosing diagnoses if nurses don't diagnose?

The primary point is that you are able to **Recognize S&S, critically think, & act if needed.**

Nurses are typically the first people to recognize a status change - and when your patient does have a status change, you need to be able to say: *"I am noticing a status change and am concerned with..."*

NURSING CARE PLAN

Also called: **CARE PLAN** • **CARE MAP** • **CONCEPT MAP** • **ETC.**

The Nursing Process: ADPIE MNEMONIC "A DELICIOUS PIE"

A — Assess

- Gather information (subjective & objective data)
- Verify the information collected is clear & accurate

SUBJECTIVE DATA
What the client tells the nurse

Example:
"My stomach has been cramping for 2 days."

OBJECTIVE DATA
Data the nurse obtains through their assessmsent & observations

Example:
Lab values, vital signs, bowel sounds, etc.

D — Diagnosis

- Interpret the information collected
- Identify & prioritize the problem through a **nursing diagnosis**

A ***nursing diagnosis*** can be written according to the 4 main categories:

1. Actual (focused on true & existing problem)
2. Risk (risk for a negative outcome)
3. Promotion of health
4. Syndrome

EXAMPLE:
Risk for infection,
Impaired gas exchange

Most schools require it to be NANDA approved

P — Plan

- Set **realistic and patient-centered GOALS, supported by a plan** to solve the problem
- Prioritize the outcomes of care
- **Priority** is given to life-threatening issues (ABCs)

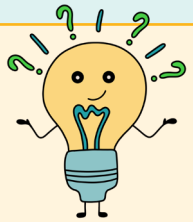
MNEMONIC Set **SMART** goals:
Specific
Measurable
Achievable
Relevant
Time frame

Airway
Breathing
Circulation

I — Implement

- Put plan into place
- Include interventions, mobility, assessments, etc.
- **This is the stage in which physical actions & care take place**

E — Evaluate



- **Determine the outcome of goals according to plan**
  - Have the desired goals been met?
  - Was the plan effective?
- **Evaluate client's compliance with the plan**
  - Was the patient able to follow the plan or comply with implemented care?
  - Document client's response to interventions
  - Modify & assess for needed change

NCSBN CLINICAL JUDGMENT MEASUREMENT MODEL (CJMM)

Currently, (early 2023), the ADPIE model still applies to nursing processes and care planning. The Clinical Judgment Measurement Model (CJMM) has been introduced and is also very useful for measuring your critical thinking, evaluating your thoughts, and viewing outcomes of plans. The CJMM is BASED on the ADPIE model, and **both** are helpful to know.

Remember: the goal of a care plan, regardless of the model used, is to organize priorities of patient care, implement positive actions to help patients reach individualized goals, and for nurses to evaluate and adapt accordingly!

Recognize cues **A**ssessment	**"What matters most?"**
Analyze cues **A**nalysis	**"What could it mean?"**
Prioritize hypothesis **A**nalysis	**"Where do I start?"**
Generate solutions **P**lanning	**"What can I do?"**
Take action **I**mplementation	**"What will I do?"**
Evaluate outcomes **E**valuation	**"Did it help?"**

MEMORY TRICK

The CJMM follows the nursing process: **An Apple PIE**
Assessment, **A**nalysis, **P**lanning, **I**mplementation, **E**valuation

NURSING CARE PLAN

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A Assessment

- Gather information (subjective & objective data)
- Verify the information collected is clear & accurate

SUBJECTIVE DATA
(patient report)

&

OBJECTIVE DATA
(values, numbers, proven information)

D Diagnosis (your written piece)

1. NANDA-approved nursing diagnosis (use 1 of 4 categories)

Examples:
impaired mobility, risk for falls, readiness for smoking cessation, pain, etc.

2. Related to

Think: What was the CAUSE of #1?

3. As evidenced by

Assessment points by the nurse (objective & subjective data to support the diagnosis)

P Plan (include realistic, attainable, and measurable goals!)

EXAMPLES:

- "Patient will experience..."
- "Improved ____ will be seen in _____ weeks"
- "Patient will _____ by end of shift" life-threatening issues (ABCs)

Use realistic timelines for goals to be achieved

Example:
"Patient will experience managed pain levels by end of shift"

I Implement: act, care, educate and perform interventions

1. What nursing ***interventions*** will you perform?

2. Briefly add the ***rationale*** for why you selected those nursing interventions

Example:
"Patient will be turned & positioned every 2 hours to provide offloading of pressure points & prevention of further breakdown"

intervention

rationale

E Evaluate

Evaluate patient's:

- Compliance
- Response
- Improvement, if seen
- Acceptance

It is your job to:

- Create new goals if needed
- Document positive/negative outcomes
- Document lack of progress
- Reorganize the plan

EXAMPLES:

- "Patient did not comply with..."
- "Time & daily routine did not allow for..."
- "_____ was successful, with notably improved_____."

NANDA

What is NANDA?

NANDA = North American Nursing Diagnosis Association

What is NANDA approved & how do I know if my diagnosis is legitimate?

- Nursing diagnoses should be "NANDA-approved", meaning the terminology should be deemed appropriate and fitting by the association
- NANDA.org has multiple resources dedicated to education & matching approved terminology
- When creating your nursing care plan, be sure the MAIN PORTION (diagnosis) has approved terminology!
- NANDA has hundreds of approved terms & nursing diagnoses

NANDA has FOUR MAIN CATEGORIES for nursing diagnoses:

Here are some commonly-used examples

1 ACTUAL
(Problem-Focused)

- Impaired mobility...
- Ineffective breathing pattern...
- Fluid volume excess...
- ↓ cardiac output...
- Pain...
- Altered mental status...

2 RISK

- ***Risk*** for infection...
- ***Risk*** for fall...
- ***Risk*** for injury...
- ***Risk*** for harm to self or others...

3 PROMOTION OF HEALTH

- ***Readiness*** for enhanced knowledge...
- ***Readiness*** for enhanced nutrition...
- ***Readiness*** for breastfeeding...
- ***Readiness*** to discuss smoking cessation...

4 SYNDROME

- Post-traumatic stress syndrome...
- Chronic Fatigue syndrome...
- Chronic Pain syndrome...

PRIORITIZATION

Prioritize in nursing care plans
JUST as you would in a real-life situation!

USE YOUR ABCs & THINK ABOUT SAFETY!

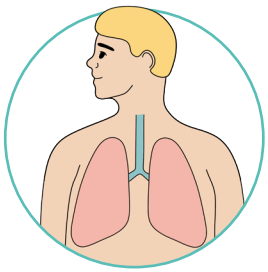
A Airway

ASK YOURSELF:

Can they successfully breathe oxygen in and breathe CO_2 out?

- Maintaining or establishing a patent airway
- Prevention of occlusion
- Prevention of choking
- Aspiration precautions
- Cervical spine stabilization

B Breathing

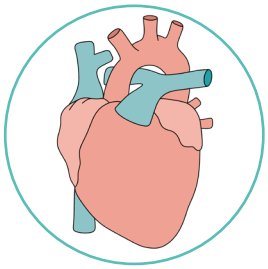


ASK YOURSELF:

Can gas exchange successfully happen in their lungs?

- Oxygen administration
- Monitoring SpO_2 & respiratory rate
- Lung assessments & lung sounds

C Circulation



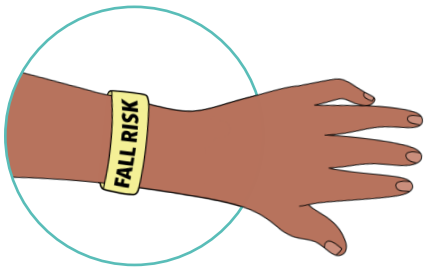
ASK YOURSELF:

Is there a reason that the blood isn't pumping/circulating in the body?

(Example: The heart is working to pump the blood to the vital organs)

- Monitoring & preventing bleeding
- Clot prevention & DVT prophylaxis
- Monitoring heart rate, blood pressure, and SpO_2
- Fluid volume replacement/fluid resuscitation

Other SAFETY measures



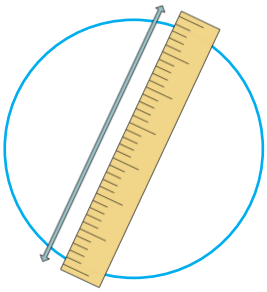
- Fall prevention
- Injury prevention
- Monitoring electrolyte balance
- Seizure precautions & prevention
- Medication compliance

GOAL SETTING

Goals created in the "Planning" stage should be **"SMART"**

SPECIFIC

- Make goals individualized
- Avoid being too "broad"
- Include information specific to patient & current health status
  - *Example:* wheelchair use, underlying diagnoses, bedrest order, left arm precautions after mastectomy, etc.



MEASURABLE

- Include numbers and values wherever possible, there needs to be a way to actually MEASURE if the goal is being met or not
  - *Example:* lab values, heart rate, temperature, distance ambulated, glucose levels

ACHIEVABLE

- Use your nursing judgment to determine if the goal is REALISTIC
- Setting unrealistic goals can lead to discouraging feelings & decreased patient self-esteem

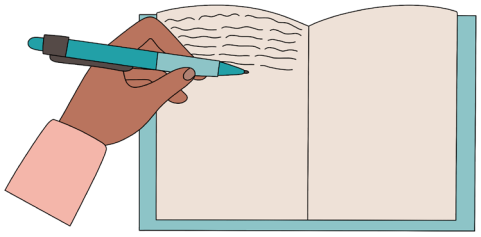
RELEVANT

- Is the goal relevant and does it relate to the patient?
  - *Example:* Don't make a goal regarding ambulation if the patient is wheelchair or bed-bound
- Is the goal relevant to the diagnosis?
  - If the diagnosis is in regards to respiratory health, the goals should focus around pulmonary and respiratory care
  - Avoid involving random or unrelated information

TIME FRAME

- Can the goal be achieved within a projected time frame?
- Is the goal realistic to achieve within the time frame you have given?

HELPFUL TERMINOLOGY TO USE



When documenting PLANNING & IMPLEMENTATION portions

"Nurse will perform assessments, care, etc."

"Safety measures will be implemented..."

"____ precautions will be initiated"

"Environment will remain free of..."

"____ will occur per health care provider orders"

"Nurse will educate patient on ____"

"Focused assessments of ____ will be performed every ____"

When documenting EVALUATION portion...

SUCCESSFUL IMPLEMENTATIONS

Patient...

- ✓ ...exhibits understanding
- ✓ ...is able to provide proper teach back to nurse
- ✓ ...able to perform
- ✓ ...verbalizes understanding

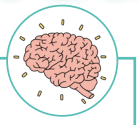
PLANS & IMPLEMENTATIONS NEEDING CHANGE

Patient...

- ✘ ...does not exhibit understanding
- ✘ ...is unable to provide proper teach back to nurse
- ✘ ...unable to tolerate
- ✘ ...experienced decreased
- ✘ ...experienced worsening

CONCEPTS & SAMPLE DIAGNOSES

NEUROLOGICAL

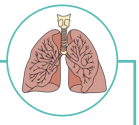


- Altered sensation related to...
- Impaired cognitive function related to...
- Altered mental status related to...
- Self-care deficit related to...
- Impaired verbal communication...
- Impaired cerebral perfusion related to...

CARDIAC

- Fluid volume excess related to...
- Self-care deficit related to...
- Activity intolerance related to...
- Decreased cardiac output related to...
- Impaired/ineffective tissue perfusion related to...

RESPIRATORY

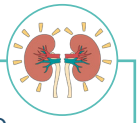


- Impaired gas exchange related to...
- Altered mental status related to...
- Activity intolerance related to...
- Ineffective airway clearance related to...
- Impaired tissue perfusion related to...
- Risk for infection related to...

GASTROINTESTINAL

- Risk for infection related to...
- Imbalanced nutrition (more/less than body requirements) related to...
- Acute pain related to...
- Risk for constipation/diarrhea related to...
- Altered bowel elimination pattern related to...
- Impaired skin integrity related to...

RENAL/URINARY



- Impaired urinary elimination related to...
- Risk for infection related to...
- Acute pain related to...
- Risk for fall related to...
- Altered mental status related to...
- Fluid volume excess related to...

ENDOCRINE

- Disturbed sensory perception related to...
- Unstable blood glucose level related to...
- Risk for injury related to...
- Imbalanced nutrition (more/less than body requirements) related to...
- Risk for infection related to...
- Acute pain related to...

SKIN, WOUND, & INCISION

- Disturbed sensory perception related to...
- Risk for infection related to...
- Impaired skin integrity related to...
- Delayed wound healing related to...
- Risk for skin breakdown related to...
- Acute pain related to...

MENTAL HEALTH

- Altered mental status related to....
- Risk for injury related to...
- Ineffective communication related to...
- Self-care deficit related to...
- Disturbed thought processes related to...
- Disturbed sleep pattern related to...

LIFESTYLE HABITS AND/OR CHANGE

- Knowledge deficit related to....
- Readiness to discuss smoking cessation related to...
- Self-care deficit related to...

EXAMPLE #1: STROKE

A Assessment

SUBJECTIVE DATA

Patient reports:

- "My legs feel weak"
- "I feel very unsteady when up with my walker"
- "I cannot feel the left side of my body"

OBJECTIVE DATA

- Left-sided facial droop
- Asymmetrical strength (right = 5/5, left 2/5)
- Aphasia
- Productive, moist cough
- Dysphagia
- Stage I pressure wound to coccyx & left buttock
- Incontinent of bowel and bladder

D Diagnosis

1. NANDA-approved nursing diagnosis	**2.** Related to	**3.** As evidenced by
▪ Impaired mobility	▪ Hemiparesis	▪ Nonblanchable redness to coccyx & right buttock
▪ Impaired sensation	▪ Lack of coordinated movements	▪ Coughing after oral intake
▪ Risk for fall	▪ Inability to ambulate	▪ Asymmetrical extremity strength
▪ Risk for aspiration	▪ Immobility	▪ Moist, productive cough
▪ Activity intolerance	▪ Incontinence	
▪ Impaired skin integrity	▪ Sensory deficits	

P Plan

Think:
Realistic & helpful
GOALS

- Nurse will note no further skin breakdown within 1 week
- Redness will improve within 1 week of implemented care
- The patient will be free of pain or discomfort at coccyx & buttock sites
- The patient will experience no episodes of coughing with oral intake or choking
- The patient will experience no falls within 1 month of implementation
- The patient will remain free of respiratory infection within 1 month of implementation

I Implement

- Turn & Position Q2H to prevent further breakdown
- Ambulate 20 feet with 1 person assist and walker at least once every 6 hours
- Nurse/caregiver will use barrier cream to prevent skin breakdown
- Monitor for moisture & change brief every hour to prevent maceration
- Aspiration precautions will be used to prevent episodes of choking or coughing with oral intake
- 1:1 feed & meal times
- Focused lung assessments will be performed every 4 hours and as needed to assess for change
- Physical therapy sessions will be implemented twice per day to maintain strength and range of motion

E Evaluate

- No episodes of coughing after oral intake were noted during 1:1 feed & meals
- Lungs remained clear during each assessment during week. No crackles, rales, rhonchi, or fevers noted
- Patient able to ambulate 10 feet every 6 hours with assistance and walker, rather than goal of 20 feet
- No further breakdown of the skin noted. Mild, non-blanchable redness noted
- No maceration, excoriation, or shearing noted

This is where nurse will evaluate effectiveness of plan & make changes to the care plan where needed!

EXAMPLE #2: COPD EXACERBATION

A Assessment

SUBJECTIVE DATA

Patient reports:

- Dizziness with standing & ambulation
- Shortness of breath when lying down

OBJECTIVE DATA

- SpO_2: 90% on 2L O_2 via nasal cannula (on room air at baseline)
- Rhonchi & expiratory wheezes noted to lungs bilaterally
- Dyspneic on exertion & with ambulation
- Moist, non-productive cough

D Diagnosis

1. NANDA-approved nursing diagnosis

- Activity intolerance
- Impaired gas exchange
- Risk for infection

2. Related to

- Excessive secretions
- Ineffective airway clearance
- Poor perfusion
- Fatigue from coughing

3. As evidenced by

- Decreased SpO_2 levels from 90% to 87% while ambulating
- Labored breathing
- Moist, non-productive cough
- Increased wheezing

P Plan

Think:
Realistic & helpful
GOALS

- Patient will have improved sleep patterns undisturbed by coughing spells for at least 2-4 hours at a time
- Patient will be able to ambulate at least 10 feet with portable oxygen for toileting
- Patient's oxygen levels will return to baseline (92% on room air) before discharge
- Patient will verbalize understanding of incentive spirometer use & prevention of atelectasis

I Implement

- Teach incentive spirometer with patient teachback method
- Incentive spirometer use 2-3 times per hour
- Oxygen weaning & room air trials per health care provider orders to attempt return to baseline
- Focused lung assessments at least once per shift
- Implement fall risk precautions with oxygen tubing and risk for unsteadiness
- Monitor vital signs every 4 hours
- Implement continuous pulse-oximetry monitoring
- Create quiet, calm environment conducive to rest
- Cluster care to minimize sleep disturbance

E Evaluate

- Patient continues to participate in oxygen weaning trials daily with improvement from 90% 2L via nasal cannula to 91% on room air
- Patient verbalizes and exhibits understanding and use of incentive spirometer, with use 2 times per hour
- Lung assessments yield no note of crackles, rales, or rhonchi
- Vital signs remain stable, will change from every 4 hours to every 8 hours
- Continue continuous pulse oximetry monitoring until discharge

BLANK TEMPLATE: (CREATE YOUR OWN)

A Assessment

SUBJECTIVE DATA

OBJECTIVE DATA

D Diagnosis

1. NANDA-approved nursing diagnosis

2. Related to

3. As evidenced by

P Plan

I Implement

E Evaluate

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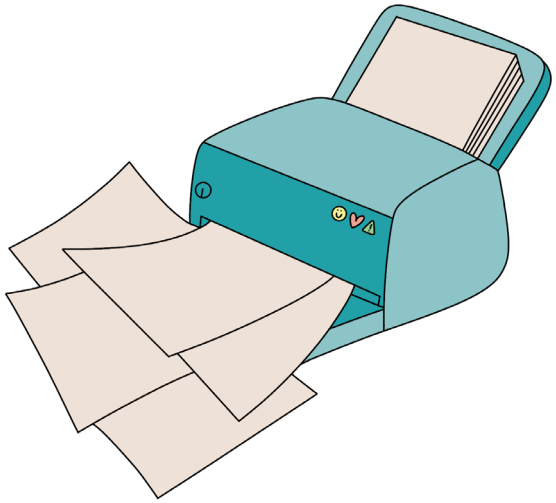
Dear future nurse,

You may be stressed, you may feel tired, and you may want to give up. Nursing school is hard, there's no doubt about it. Everyone cries, everyone has meltdowns, and there will be moments you don't feel qualified for the task at hand. But take heart, the challenge only makes you stronger. Put in the work, show up on time, and find an amazing study group. You got this! ☺

— Kristine Tuttle, BSN, RN



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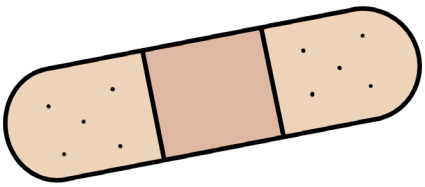
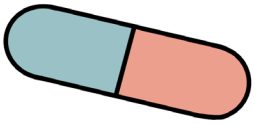
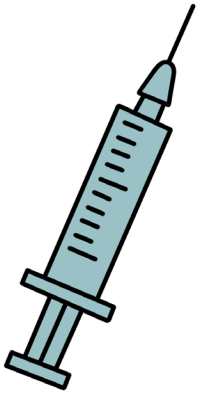
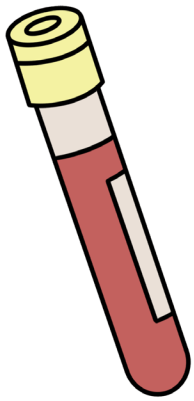
GUIDE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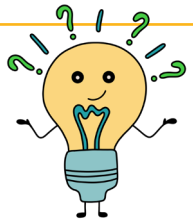
Circulation

I Implement

- Put plan into place
- Include interventions, mobility, assessments, etc.
- **This is the stage in which physical actions & care take place**

E Evaluate



- **Determine the outcome of goals according to plan**
  - Have the desired goals been met?
  - Was the plan effective?
- **Evaluate client's compliance with the plan**
  - Was the patient able to follow the plan or comply with implemented care?
  - Document client's response to interventions
  - Modify & assess for needed change

NCSBN CLINICAL JUDGMENT MEASUREMENT MODEL (CJMM)

Currently, (early 2023), the ADPIE model still applies to nursing processes and care planning. The Clinical Judgment Measurement Model (CJMM) has been introduced and is also very useful for measuring your critical thinking, evaluating your thoughts, and viewing outcomes of plans. The CJMM is BASED on the ADPIE model, and **both** are helpful to know.

Remember: the goal of a care plan, regardless of the model used, is to organize priorities of patient care, implement positive actions to help patients reach individualized goals, and for nurses to evaluate and adapt accordingly!

Recognize cues
Assessment
"What matters most?"

Analyze cues
Analysis
"What could it mean?"

Prioritize hypothesis
Analysis
"Where do I start?"

Generate solutions
Planning
"What can I do?"

Take action
Implementation
"What will I do?"

Evaluate outcomes
Evaluation
"Did it help?"

MEMORY TRICK

The CJMM follows the nursing process: **An Apple PIE**
Assessment, **A**nalysis, **P**lanning, **I**mplementation, **E**valuation

NURSING CARE PLAN

Also called: **CARE PLAN** • **CARE MAP** • **CONCEPT MAP** • **ETC.**

A Assessment

- Gather information (subjective & objective data)
- Verify the information collected is clear & accurate

SUBJECTIVE DATA
(patient report)

&

OBJECTIVE DATA
(values, numbers, proven information)

D Diagnosis (your written piece)

1. NANDA-approved nursing diagnosis (use 1 of 4 categories)

Examples:
impaired mobility, risk for falls, readiness for smoking cessation, pain, etc.

2. Related to

Think: What was the CAUSE of #1?

3. As evidenced by

Assessment points by the nurse (objective & subjective data to support the diagnosis)

P Plan (include realistic, attainable, and measurable goals!)

EXAMPLES:

- "Patient will experience..."
- "Improved ____ will be seen in _____ weeks"
- "Patient will _____ by end of shift" life-threatening issues (ABCs)

Use realistic timelines for goals to be achieved

Example:
"Patient will experience managed pain levels by end of shift"

I Implement: act, care, educate and perform interventions

1. What nursing ***interventions*** will you perform?

2. Briefly add the ***rationale*** for why you selected those nursing interventions

Example:
"Patient will be turned & positioned every 2 hours to provide offloading of pressure points & prevention of further breakdown"

intervention

rationale

E Evaluate

Evaluate patient's:

- Compliance
- Response
- Improvement, if seen
- Acceptance

It is your job to:

- Create new goals if needed
- Document positive/negative outcomes
- Document lack of progress
- Reorganize the plan

EXAMPLES:

- "Patient did not comply with..."
- "Time & daily routine did not allow for..."
- "_____ was successful, with notably improved_____."

NANDA

What is NANDA?

NANDA = North American Nursing Diagnosis Association

What is NANDA approved & how do I know if my diagnosis is legitimate?

- Nursing diagnoses should be "NANDA-approved", meaning the terminology should be deemed appropriate and fitting by the association
- NANDA.org has multiple resources dedicated to education & matching approved terminology
- When creating your nursing care plan, be sure the MAIN PORTION (diagnosis) has approved terminology!
- NANDA has hundreds of approved terms & nursing diagnoses

NANDA has FOUR MAIN CATEGORIES for nursing diagnoses:

Here are some commonly-used examples

1 ACTUAL

(Problem-Focused)

- Impaired mobility...
- Ineffective breathing pattern...
- Fluid volume excess...
- ↓ cardiac output...
- Pain...
- Altered mental status...

2 RISK

- ***Risk*** for infection...
- ***Risk*** for fall...
- ***Risk*** for injury...
- ***Risk*** for harm to self or others...

3 PROMOTION OF HEALTH

- ***Readiness*** for enhanced knowledge...
- ***Readiness*** for enhanced nutrition...
- ***Readiness*** for breastfeeding...
- ***Readiness*** to discuss smoking cessation...

4 SYNDROME

- Post-traumatic stress syndrome...
- Chronic Fatigue syndrome...
- Chronic Pain syndrome...

PRIORITIZATION

Prioritize in nursing care plans
JUST as you would in a real-life situation!

USE YOUR ABCs & THINK ABOUT SAFETY!

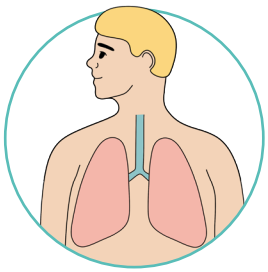
A Airway

ASK YOURSELF:

Can they successfully breathe oxygen in and breathe CO_2 out?

- Maintaining or establishing a patent airway
- Prevention of occlusion
- Prevention of choking
- Aspiration precautions
- Cervical spine stabilization

B Breathing

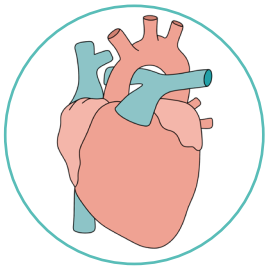


ASK YOURSELF:

Can gas exchange successfully happen in their lungs?

- Oxygen administration
- Monitoring SpO_2 & respiratory rate
- Lung assessments & lung sounds

C Circulation



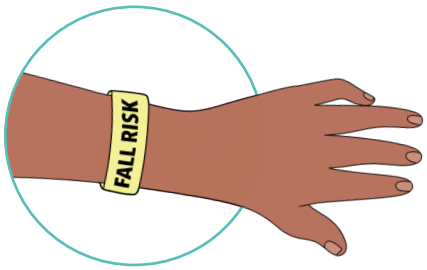
ASK YOURSELF:

Is there a reason that the blood isn't pumping/circulating in the body?

(Example: The heart is working to pump the blood to the vital organs)

- Monitoring & preventing bleeding
- Clot prevention & DVT prophylaxis
- Monitoring heart rate, blood pressure, and SpO_2
- Fluid volume replacement/fluid resuscitation

Other SAFETY measures



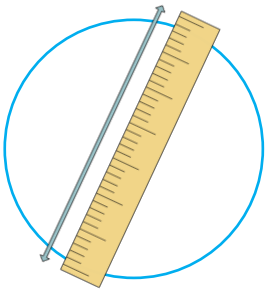
- Fall prevention
- Injury prevention
- Monitoring electrolyte balance
- Seizure precautions & prevention
- Medication compliance

GOAL SETTING

Goals created in the "Planning" stage should be **"SMART"**

SPECIFIC

- Make goals individualized
- Avoid being too "broad"
- Include information specific to patient & current health status
  - *Example:* wheelchair use, underlying diagnoses, bedrest order, left arm precautions after mastectomy, etc.



MEASURABLE

- Include numbers and values wherever possible, there needs to be a way to actually MEASURE if the goal is being met or not
  - *Example:* lab values, heart rate, temperature, distance ambulated, glucose levels

ACHIEVABLE

- Use your nursing judgment to determine if the goal is REALISTIC
- Setting unrealistic goals can lead to discouraging feelings & decreased patient self-esteem

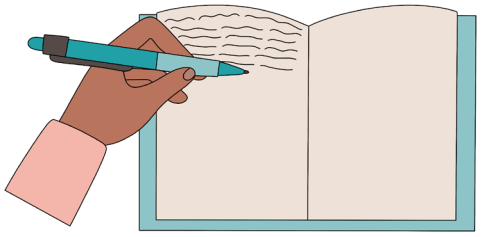
RELEVANT

- Is the goal relevant and does it relate to the patient?
  - *Example:* Don't make a goal regarding ambulation if the patient is wheelchair or bed-bound
- Is the goal relevant to the diagnosis?
  - If the diagnosis is in regards to respiratory health, the goals should focus around pulmonary and respiratory care
  - Avoid involving random or unrelated information

TIME FRAME

- Can the goal be achieved within a projected time frame?
- Is the goal realistic to achieve within the time frame you have given?

HELPFUL TERMINOLOGY TO USE



When documenting PLANNING & IMPLEMENTATION portions

"Nurse will perform assessments, care, etc."

"Safety measures will be implemented..."

"____ precautions will be initiated"

"Environment will remain free of..."

"____ will occur per health care provider orders"

"Nurse will educate patient on ____"

"Focused assessments of ____ will be performed every ____"

When documenting EVALUATION portion...

SUCCESSFUL IMPLEMENTATIONS

Patient...

- ✓ ...exhibits understanding
- ✓ ...is able to provide proper teach back to nurse
- ✓ ...able to perform
- ✓ ...verbalizes understanding

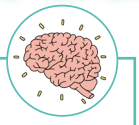
PLANS & IMPLEMENTATIONS NEEDING CHANGE

Patient...

- ✘ ...does not exhibit understanding
- ✘ ...is unable to provide proper teach back to nurse
- ✘ ...unable to tolerate
- ✘ ...experienced decreased
- ✘ ...experienced worsening

CONCEPTS & SAMPLE DIAGNOSES

NEUROLOGICAL

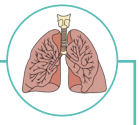


- Altered sensation related to...
- Impaired cognitive function related to...
- Altered mental status related to...
- Self-care deficit related to...
- Impaired verbal communication...
- Impaired cerebral perfusion related to...

CARDIAC

- Fluid volume excess related to...
- Self-care deficit related to...
- Activity intolerance related to...
- Decreased cardiac output related to...
- Impaired/ineffective tissue perfusion related to...

RESPIRATORY

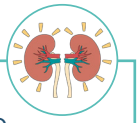


- Impaired gas exchange related to...
- Altered mental status related to...
- Activity intolerance related to...
- Ineffective airway clearance related to...
- Impaired tissue perfusion related to...
- Risk for infection related to...

GASTROINTESTINAL

- Risk for infection related to...
- Imbalanced nutrition (more/less than body requirements) related to...
- Acute pain related to...
- Risk for constipation/diarrhea related to...
- Altered bowel elimination pattern related to...
- Impaired skin integrity related to...

RENAL/URINARY



- Impaired urinary elimination related to...
- Risk for infection related to...
- Acute pain related to...
- Risk for fall related to...
- Altered mental status related to...
- Fluid volume excess related to...

ENDOCRINE

- Disturbed sensory perception related to...
- Unstable blood glucose level related to...
- Risk for injury related to...
- Imbalanced nutrition (more/less than body requirements) related to...
- Risk for infection related to...
- Acute pain related to...

SKIN, WOUND, & INCISION

- Disturbed sensory perception related to...
- Risk for infection related to...
- Impaired skin integrity related to...
- Delayed wound healing related to...
- Risk for skin breakdown related to...
- Acute pain related to...

MENTAL HEALTH

- Altered mental status related to....
- Risk for injury related to...
- Ineffective communication related to...
- Self-care deficit related to...
- Disturbed thought processes related to...
- Disturbed sleep pattern related to...

LIFESTYLE HABITS AND/OR CHANGE

- Knowledge deficit related to....
- Readiness to discuss smoking cessation related to...
- Self-care deficit related to...

EXAMPLE #1: STROKE

A Assessment

SUBJECTIVE DATA

Patient reports:

- "My legs feel weak"
- "I feel very unsteady when up with my walker"
- "I cannot feel the left side of my body"

OBJECTIVE DATA

- Left-sided facial droop
- Asymmetrical strength (right = 5/5, left 2/5)
- Aphasia
- Productive, moist cough
- Dysphagia
- Stage I pressure wound to coccyx & left buttock
- Incontinent of bowel and bladder

D Diagnosis

1. NANDA-approved nursing diagnosis

- Impaired mobility
- Impaired sensation
- Risk for fall
- Risk for aspiration
- Activity intolerance
- Impaired skin integrity

2. Related to

- Hemiparesis
- Lack of coordinated movements
- Inability to ambulate
- Immobility
- Incontinence
- Sensory deficits

3. As evidenced by

- Nonblanchable redness to coccyx & right buttock
- Coughing after oral intake
- Asymmetrical extremity strength
- Moist, productive cough

P Plan

Think:
Realistic & helpful
GOALS

- Nurse will note no further skin breakdown within 1 week
- Redness will improve within 1 week of implemented care
- The patient will be free of pain or discomfort at coccyx & buttock sites
- The patient will experience no episodes of coughing with oral intake or choking
- The patient will experience no falls within 1 month of implementation
- The patient will remain free of respiratory infection within 1 month of implementation

I Implement

- Turn & Position Q2H to prevent further breakdown
- Ambulate 20 feet with 1 person assist and walker at least once every 6 hours
- Nurse/caregiver will use barrier cream to prevent skin breakdown
- Monitor for moisture & change brief every hour to prevent maceration
- Aspiration precautions will be used to prevent episodes of choking or coughing with oral intake
- 1:1 feed & meal times
- Focused lung assessments will be performed every 4 hours and as needed to assess for change
- Physical therapy sessions will be implemented twice per day to maintain strength and range of motion

E Evaluate

- No episodes of coughing after oral intake were noted during 1:1 feed & meals
- Lungs remained clear during each assessment during week. No crackles, rales, rhonchi, or fevers noted
- Patient able to ambulate 10 feet every 6 hours with assistance and walker, rather than goal of 20 feet
- No further breakdown of the skin noted. Mild, non-blanchable redness noted
- No maceration, excoriation, or shearing noted

This is where nurse will evaluate effectiveness of plan & make changes to the care plan where needed!

EXAMPLE #2: COPD EXACERBATION

A Assessment

SUBJECTIVE DATA

Patient reports:

- Dizziness with standing & ambulation
- Shortness of breath when lying down

OBJECTIVE DATA

- SpO_2: 90% on 2L O_2 via nasal cannula (on room air at baseline)
- Rhonchi & expiratory wheezes noted to lungs bilaterally
- Dyspneic on exertion & with ambulation
- Moist, non-productive cough

D Diagnosis

1. NANDA-approved nursing diagnosis

- Activity intolerance
- Impaired gas exchange
- Risk for infection

2. Related to

- Excessive secretions
- Ineffective airway clearance
- Poor perfusion
- Fatigue from coughing

3. As evidenced by

- Decreased SpO_2 levels from 90% to 87% while ambulating
- Labored breathing
- Moist, non-productive cough
- Increased wheezing

P Plan

Think:
Realistic & helpful
GOALS

- Patient will have improved sleep patterns undisturbed by coughing spells for at least 2-4 hours at a time
- Patient will be able to ambulate at least 10 feet with portable oxygen for toileting
- Patient's oxygen levels will return to baseline (92% on room air) before discharge
- Patient will verbalize understanding of incentive spirometer use & prevention of atelectasis

I Implement

- Teach incentive spirometer with patient teachback method
- Incentive spirometer use 2-3 times per hour
- Oxygen weaning & room air trials per health care provider orders to attempt return to baseline
- Focused lung assessments at least once per shift
- Implement fall risk precautions with oxygen tubing and risk for unsteadiness
- Monitor vital signs every 4 hours
- Implement continuous pulse-oximetry monitoring
- Create quiet, calm environment conducive to rest
- Cluster care to minimize sleep disturbance

E Evaluate

- Patient continues to participate in oxygen weaning trials daily with improvement from 90% 2L via nasal cannula to 91% on room air
- Patient verbalizes and exhibits understanding and use of incentive spirometer, with use 2 times per hour
- Lung assessments yield no note of crackles, rales, or rhonchi
- Vital signs remain stable, will change from every 4 hours to every 8 hours
- Continue continuous pulse oximetry monitoring until discharge

BLANK TEMPLATE: (CREATE YOUR OWN)

A Assessment

SUBJECTIVE DATA

OBJECTIVE DATA

D Diagnosis

1. NANDA-approved nursing diagnosis

2. Related to

3. As evidenced by

P Plan

I Implement

E Evaluate