NURSING CARE PLAN GUIDELINES- Juniors

Firelands Regional Medical Center School of Nursing
Faculty Manual

Nursing Diagnosis:

- Select the priority nursing diagnosis
- The problem statement must be NANDA approved (ex. Acute Pain, Impaired Gas Exchange, etc.)
- No medical diagnoses in the etiology
- Defining characteristics:
    - At least three to support a nursing diagnosis
    - Be specific (instead of saying adventitious lung sounds, say crackles posteriorly at the left lung base during inspiration and expiration)
    - Make sure they directly relate to the diagnosis you have chosen

Goal and Outcome:

- Start with one (1) generalized goal
    - This is a positive statement that directly relates to the NANDA problem (ex. Patient will display improved skin integrity aeb:)
- Next identify your outcomes: each outcome must be specific, measurable, attainable, realistic, and include a timeframe for completion (SMART) (ex. the left hip surgical incision is free of erythema)
    - For every defining characteristic that you included in the nursing diagnosis, you will turn it into a positive assessment and add it to the detailed section of the outcome (ex. if you include the following defining characteristics into your nursing diagnosis:
        - Constant, throbbing pain at 10/10 in the right foot at rest
        - Facial grimacing with movement of right foot
        - BP 158/110
    - The outcome will include:
        - Pain less than or equal to 3/10 in the right foot at rest (not decreased or improved pain, as that is not measurable)
        - Absence of facial grimacing with movement of right foot
        - SBP 100-130 and DBP 70-90
    - And then don't forget to include your timeframe (ex. by discharge)

Interventions:

- A <u>minimum</u> of five (5) interventions should be included into a care plan, however, you should include ALL pertinent interventions for your patient.
- Each intervention should state what, when, and how often the nurse will do something.
- The interventions should be individualized and realistic for your specific patient.
- Each intervention should be pertinent to the nursing diagnosis (ex. though a patient's PT/INR is high, would it be appropriate to have an intervention for monitoring the INR if

your care plan is about Chronic Pain? The answer is no, but it would definitely fit in another care plan).

- Include specific medications for your patients individualized care plan. Include the name of the medication and frequency, but only include medications that are specific to the patient's plan of care. For example, if care plan is for pain, then include pain medications, but not medications for his/her blood pressure.
- Each intervention should include a rationale or a reason why the nurse is completing the intervention (it is not enough to simple say to check for changes VS, etc.; explain specifically why you are assessing for these changes).
- Most care plans should include assessments, interventions that will directly help the problem, a medication related intervention, and an education related intervention.
- Be sure to prioritize your intervention list with <u>assessments taking the highest priority</u>.
- A complete intervention may look like these:
    - 1. Assess the patients urine (color, odor, concentration, and output) q8h (1400, 2200, 0600) or PRN with each void
        - To determine whether or not the S&S of the UTI are resolving
    - 2. Administer Levafloxacin 500mg IVPB q24h at 0900
        - To treat the patients UTI
    - 3. Educate the patient regarding appropriate perineal hygiene daily (1000)
        - To promote self-care and prevent future UTI's

Evaluation:

- This section directly reflects content included in the defining characteristics of the goal and outcome statement.
- Start with the date of your evaluation and a statement that reflects the achievement of the goal (ex. Goal Met aeb:, Goal Partially Met aeb:, Goal Not Met aeb:).
- Next, include your assessment of the patient as it relates to <u>each</u> piece of the outcome (evaluate each of the "as evidenced by" in your outcome statement).
- Based on the patient's progress, you will then decide to continue or terminate the plan of care and include your signature.
- This is an example of a complete evaluation:
    - 3/14/14 Goal partially met aeb:
        - Patient describes pain as intermittent, throbbing at a 4/10 in the right foot at rest
        - No facial grimacing noted during movement of the right foot
        - BP 126/84
    - Continue Plan of Care
    - D. Wikel, SN FRMC

Nursing Care Plans Grading Rubric
MSN
2021

Student Name: **Clinical Date**

Objective # 6: Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*	
****Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating**	Total Points Comments
Nursing Diagnosis: (3 points) Problem Statement (1) Etiology (1) Defining Characteristics (1)	Total Points Comments:
Goal and Outcome (6 points total) Goal Statement (1 point) Outcome: Specific (1) Measurable (1) Attainable (1) Realistic (1) Time Frame (1)	Total Points Comments:
Nursing Interventions: (8 points total) Prioritized (1) What (1) How Often (1) When (1) Individualized (1) Realistic (1) Rationale (1) All pertinent interventions listed (1)	Total Points Comments:
Evaluation: (5 points total) Date (1) Goal Met/partially/unmet (1) Defining characteristics (1) Plan to continue/terminate (1) Signature (1)	Total Points Comments:
Total possible points = 22 18-22 = Satisfactory care plan 17-14 = Needs improvement care plan <13 = Unsatisfactory care plan	Total Points for entire Care plan = Comments: