GUIDELINES FOR WRITING NURSING CARE PLANS

Actual Nursing Diagnosis	Nursing Diagnosis	Patient Outcomes	Related Interventions	Evaluation
Date: Note the date that the problem is identified as a nursing diagnosis. Place the initials of the person writing the care plan next to the date. List a number indicating the priority of the problem. Actual nursing diagnoses are always prioritized before high risk.	A statement that describes the human response (health state or actual altered interaction pattern) of an individual or group which the nurse can legally identify and for which the nurse can order the definitive interventions to maintain the health state or to reduce, eliminate, or prevent alterations. An actual nursing diagnosis means that the problem has been clinically validated by identifiable defining characteristics. "The problem is now present." An actual nursing diagnosis consists of a three part statement: 1. the problem related to (r/t) 2. the probable cause and/or contributing factors 3. Defining characteristics (DC)-these are signs, symptoms, lab data, patient statements which prove that the problem actually exists.	The patient outcome is the desired patient behavior or clinical manifestation, which will indicate that the problem is resolved, is in the process of resolution, or being prevented. The patient outcome statement is taken from part one of the nursing diagnosis. The patient outcome statement should be worded in positive terms. A date or time of achievement should be stated. Patient outcome statements should be measurable, attainable and realistic.	Related interventions are nursing actions, which are individualized and designed to produce the desired change or prevent an undesirable change as identified in the nursing diagnosis. Related interventions should be written clearly so that they will not be misinterpreted. They should not require verbal explanation; if they do, others will probably not carry them out. Interventions should include: WHAT is done. WHEN it is to be done. HOW it is to be done. Begin all statements in the interventions section with a verb..."palpate, assess, monitor, etc." Prioritize interventions utilizing the nursing process.	The evaluation section should have two paragraphs. The first paragraph should address the patient's progress in meeting the desired outcome. This report may include positive or negative information. The second paragraph should evaluate the nursing diagnosis, interventions. Is what we are doing working? Is this even a problem for the patient at this point?
--- Date & Priority 1/30/09 JBR #1.	Example: --- Nursing Diagnosis Impaired physical mobility related to partial paralysis (stroke with left-sided hemiparesis). DC: left arm flaccid left leg has gross motor function Client states "Left side is useless." 8/9/08 CT scan demonstrates right-sided CVA	--- Patient Outcomes Improved mobility AEB: Walks 50 feet with quad cane prior to discharge. or Uses assistive devices to improve mobility by 2/2 or States mobility has improved after 6 sessions of physical therapy.	--- Related Interventions 1. Assess client's functional ability and range of motion on admission. 2. Assist client to reposition self on a regular schedule (even hours). 3. Support affected parts with... 4. Perform passive ROM exercises to left extremities every four hours while awake. 9-1-5 5. Teach client to exercise right extremities at the same time utilizing active ROM. 6. Coordinate plan of care with occupational and physical therapy departments. 7. etc.	--- Evaluation 2/4/09 Client willingly participates in all prescribed therapies. Ambulation with a quad cane has begun, gait is steady. Client places left arm in a splint without assistance, etc. Add intervention to consult social services to obtain home care for client. Delete interventions related to use of a walker from POC.

High Risk Nursing Diagnosis	Nursing Diagnosis	Patient Outcomes	Related Interventions	Evaluation
Date and initial problem the same as for an actual. Indicate the number of the priority.	A statement of a potential human response that a group or individual is at risk for. It should be a problem that a nurse has authority to order interventions to eliminate or prevent. A high risk nursing diagnosis is a two part statement: 1. the problem 2. the probable cause and/or contributing factors	In the case of high risk nursing diagnoses the outcome statement indicates that the problem is being prevented. It should be written in positive terms.	Nursing interventions are written in exactly the same manner as for actual nursing diagnoses.	Evaluation is written in two paragraphs just like the evaluation of an actual nursing diagnosis.
Example 1/30/098 JBR #5	Example Risk for impaired skin integrity related to immobility and thin body frame. As this is a potential problem and not an actual problem-there are no defining characteristics.	Example Skin integrity is maintained throughout hospital stay. or Client demonstrates preventative measures to maintain skin integrity throughout hospital stay. Do not write negative goals: "No breaks in skin integrity."	Example 1. Identify underlying problems that places client's skin integrity at risk on admission and q day. 2. Perform Braden Scale assessment q am. 3. Inspect skin over bony prominences with each position change-q2h-(even hours). 4. Reposition q2h-(even hours). 5. Special mattress to bed (Geo or egg crate); physician's order required. 6. Keep skin clean and dry, check with each position change. 7. etc.	Example 2/4/09 Skin over bony prominences intact. No redness, abrasions, shearing injuries noted. Client participates in turning, repositioning schedule. See Nutrition nursing diagnosis for additional evaluation. Continue plan of care without changes at this time.

Firelands Regional Medical Center School of Nursing
Medical Surgical Nursing Advanced Concepts - 2009

RECIPE FOR A SATISFACTORY CARE PLAN

Nursing Diagnoses	• Select the two most appropriate nursing diagnoses (ND) based upon assessment, pathophysiology and the patient's chief concern (complete write-up on only one) • ND involves a 2 part statement 1) problem statement & 2) related to etiology. • Medical diagnoses are not used in the problem statement or etiology
Prioritize	• Prioritize all nursing diagnoses correctly • Actual problems before high risks
Additional Nursing Diagnoses	• List additional applicable nursing diagnoses that can reflect patient care needs
Defining Characteristics	• Validate actual nursing diagnoses through the use of defining characteristics • (Proof that problem does exist; assessment findings, lab/xrays, "...", etc.) • Risk diagnoses **do not** have defining characteristics
Goal/Outcome Statements	• State in positive terms (many times can convert the nursing diagnosis into a positive statement) • Directly applicable to the nursing diagnosis listed • Target date identified & realistic
Interventions	• Individualized and realistic for your specific patient • Thorough and specific; helps answer the what, when, how of the plan (Monitor SpO_2 results when ambulating in hall q shift, 1000-1400-1800) • Starts with an action verb
Evaluation of Patient Outcomes & Evaluation of POC (2 Parts)	• "Met" or "unmet" alone are not acceptable – need to document focused assessment to verify if the outcome has been met, partially met or not met. Utilize the defining characteristics to help with this. Utilize 2 sections: • 1st section - evaluate achievement of the goal/outcome • 2nd section – evaluate the plan of care; same? modify? Problem resolved? If being discharged what might be added for continuity at discharge or education needs, etc.

Comments:

FIRELANDS REGIONAL MEDICAL CENTER

NURSING ASSESSMENT AND DIAGNOSIS

PSYCHO/SOCIAL

Parameter – Characteristics of appearance, behavior & verbalization appropriate to situation. Alert & oriented to person, place & time. Memory intact. Affect appropriate. No mood swings

- **Adjustment**, (IA) impaired
- **Anxiety**, (ANX)
- **Body-Image**, (BID) disturbance
- **Coping**, (FCIC)family, compromised
- **Coping**, (FCID family ineffective; disabling
- **Coping**, (FCGP) family, potential for growth
- **Coping**, (COPII) individual, ineffective
- Decisional **Conflict** (CONF)
- **Denial**, (DI) ineffective
- Diversional **Activity** (DAD)deficit
- **Fear** (FEAR)
- **Grieving**, Anticipatory (GRIA) Actual (GRI)
- **Grieving**, (GRID) dysfunctional
- **Hopelessness** (HOPE)
- **Knowledge** (KND) deficit
- **Noncompliance** (NC)
- **Post-trauma** (PTR) response
- **Powerlessness** (PWL)
- **Relocation** (RSS) stress syndrome
- **Self Concept** (SCD) Identity disturbance
- **Self-esteem**, (SECL) chronic low
- **Self esteem**, (SESL) situational low
- Social **Interaction**, (SINI) impaired
- Social **Isolation** (SISI)
- **Spiritual** (SPD) distress
- **Violence**, (HR.VIOL) potential for; directed at others
- Violence, self-directed **Abuse** (HR.SA) **Harm** (HR.SH) **Suicide** (HR>SUICIDE)

RESPIRATORY

Parameter – Respirations 12-20/min. at rest, quiet and regular. Breath sounds clear throughout bilateral lung fields. Skin color &/or mucous membranes pink. Absence of clubbing.

- **Airway** (IAC)clearance, ineffective
- **Breathing** (IBP) patterns, ineffective
- **Gas exchange**, (GEI) Impaired
- **Ventilation** (ISV)Inability to sustain spontaneous
- Ventilator **Weaning** (DVW) Response, dysfunctional

G U

Parameter – Able to empty bladder without dysuria. Bladder not distended after voiding. Urine is clear and yellow.

- **Urinary elimination**, (UEA) alteration in pattern

CARDIOVASCULAR

Parameter – Regular apical pulse . Neck veins flat at 45°. Pulse range 60 - 100. Peripheral pulses palpable. No edema. No calf tenderness.

- **Cardiac output**, (COD) alteration in; decreased
- **Fluid volume**, (FVD)deficit
- **Fluid volume**, (FVE) excess
- Tissues **Perfusion**, alteration in: Cerebral (TPA) myocardial (TPA) Peripheral (TPA) Renal (TPA) Vascular (TPA)

ADLS

Parameter – Pain free, able to perform activities of daily living independently.

- **Health** (HMA) Maintenance; altered
- **Home** (HMMI) Maintenance Management, Impaired
- Comfort, alteration in **Pain** (PAIN)
- **Fatigue**, (FAT) alteration in
- **Injury** (HR.INJ) potential for
- **Self-care** deficit; Feeding (SCDF), Bathing & Hygiene (SCDBH) Toileting (SCDT), Total Care (SCDTC) Dressing/grooming (SCDDG)
- **Sleep** (SPA) pattern disturbance

G I

Parameter – Abdomen soft. Bowel sounds active in all quadrants. No pain on palpation. Tolerates diet without nausea or vomiting. Having BMs within own normal pattern & consistency.

- **Bowel elimination**,(CON) alteration in constipation
- **Bowel elimination**,(DIA) alteration in diarrhea
- **Bowel elimination**,(IB) alteration in incontinence
- **Nutrition**, (NLBR)alteration in less than body requirement
- **Nutrition**, (NMBR) alteration in more than body requirement
- **Swallowing**, (SI) impaired

NEURO

Parameter – Alert & oriented to person, place & time. Behavior appropriate to situation, Pupils equal & reactive to light. Active ROM to all extremities with symmetry of strength. No paresthesia and no speech deficit.

- **Thought process**, (THPA) alteration
- Impaired verbal **Communication** (CI)
- **Sensory**, alteration Auditory (SPAA) Gustatory (SPAG), Kinesthetic (SPAK), Olfactory (SPAO), Tactile (SPAT), Visual (SPAV)

MS/SKIN

Parameter – Absence of joint swelling & tenderness. Full ROM of all joints. No muscle weakness. Uniform skin color: absence of jaundice, cyanosis, pallor, erythema, or hyper/hypopigmentation. Skin warm, dry & intact. Mucous membranes moist.

- **Activity** (AI) intolerance
- **Body Temperature** (HR.ATEMP), alteration in
- **Hyperthermia** (HYPET)
- **Hypothermia** (HYPOT)
- **Mobility** (MOBI), impaired physical
- **Skin integrity** (SII), actual impairment of Hyperthemia (HYPET) Hypothermia (HYPOT)
- Oral **Mucous membrane** (OMMA), alteration

GENERAL MED/SURG ASSESSMENT

Neuro	Alert and oriented to person, place and time. Behavior appropriate to situation. Equal hand grasps and/or moves all extremities without paresthesia.
Resp.	Respiratory rate 12-20 minutes at rest, regular and non-labored. Nailbeds and mucous membranes acyanotic.
CV	Heart sounds strong and regular. No peripheral edema.
GI	Abdomen soft, non-tender. Negative – nausea, vomiting. BMs within patient's normal pattern.
GU	Voids without difficulty Elimination within an acceptable comparison level to fluid intake.
MS/Skin	Skin warm, dry, color within patient's norm – acyanotic. Negative for joint swelling/tenderness.

See Specific System for Nursing Diagnosis

OB or PEDIATRIC PATIENTS

use unit specific form

NURSING CARE PLAN - Sample

DATE & INITIAL	NURSING DIAGNOSIS	PATIENT OUTCOMES	RELATED INTERVENTIONS	EVALUATION
2/8/09	Impaired urinary elimination	The client will have improved	1. Identify physical diagnoses that may be	1. 2/8 Voiding clear yellow
JBR	r/t multiple causality (BPH,	urinary elimination AEB:	involved for causative factors on admission	urine, 400mL at a time.
#2	prostate CA, with radiation		assessment.	Incontinent small amt on
	treatments, s/p TURP x 2)	Decreased c/o frequency,	2. Review current medication regimen on	pad, denies burning,
	(Page 554 Doenges)	Urgency, and dribbling.	admission assessment.	urgency or frequency.
			3. Determine client's previous patterns of	Up to void x2 during night.
		Verbalize causative factors.	elimination on admission.	Abdomen soft, flat, with
	Defining Characteristics:		4. Assess reports of frequency, urgency,	bladder non-palpable.
	c/o frequency,	Identify behaviors to prevent	burning, incontinence, nocturia, and force	Bladder scanner 0 residual,
	urgency,	urinary infection.	of urinary stream on admission and q shift.	Mucous membranes dry.
	dribbling,		5. Palpate bladder on admission and q shift.	Drinking 2 500ml bottles of
	decrease stream	by discharge.	6. Assess for urinary retention with bladder	Propel for day shift. Needs
	Nocturia (3-4x/night)		scanner on admission and report results.	reminding for q2h toileting
	Use of adult pads		7. Assess hygiene, perineal skin condition,	routine. Perineal area with
	Hx frequent UTIs		and mucous membranes q shift 8-4-12.	no open areas or rashes.
			8. Assess urine color, clarity, amount, q shift	Able to complete perineal
			9. Obtain specimen for u/a, C&S on adm.	hygiene and change pads
			10. Monitor I and O q shift 6-2-10.	per self appropriately.
			11. Encourage fluid intake to 3000 mL/day	Difficulty in remembering
			6am-6pm; decrease intake after 6 pm.	educational material.
			(Likes flavored water-Propel, and cranberry)	Lab work & U/A WNL.
			12. Develop toileting routines as appropriate	
			(ambulate to BR q2h) & monitor q shift.8-4-12	
			13. Monitor effects of medication; ditropan qd	2. Continue plan of care.
			14. Review lab work and urine studies when	Add consult dietitian for
			completed.	food/drink instructions and
			15. Instruct on foods/drinks that are irritating	work with family members
			to the bladder and reinforce q day.	for education interventions
			16. Instruct on causative factors contributing	and discharge planning.
			to impaired urinary elimination as needed	
			17. Discuss signs and symptoms of UTI and	
			behaviors to help prevent infection as needed	
			18. etc.	

ABG Worksheet

Step 1 Look at pH	Step 2 pH & $PaCO_2$ or HCO_3	Step 3 pH
Decide: Acidosis (↓7.40) or Alkalosis (↑7.40)	Decide: Respiratory ($PaCO_2$) or Metabolic (HCO_3) (Respiratory = opposites pH and $PaCO_2$ = ↑↓ or ↓↑) (Metabolic = the same pH and HCO_3 = ↑↑ or ↓↓)	Decide: Compensated (in the normal range) or Uncompensated or Partial compensation

Step 4 Arterial Oxygen Saturation - ? hypoxemia

Arterial Oxygen Tension ($Pa\ O_2$) less than 80 mmHg is hypoxemia
Arterial Oxygen Saturation ($Sa\ O_2$) less than 95% is hypoxemia
Pulse Oximetry Oxygen Saturation ($Sp\ O_2$) = less than 95% then hypoxemia

	Acid (A)	Normal	Alkaline (B)
pH	<7.35	7.35-7.45 (7.40)	>7.45
$PaCO_2$	>45	35-45 (40)	<35
HCO_3	<22	22-26 (24)	>26
$Pa\ O_2$	Hypoxemia <80	80-100 mmHg	
$Sa\ O_2$	Hypoxemia <95%	95-100%	
SpO_2	Hypoxemia <95%	95-100%	

Practice 1

pH	7.25
$PaCO_2$	36
HCO_3	19
PaO_2	88

Practice 2

pH	7.48
$PaCO_2$	29
HCO_3	23
PaO_2	96