



Care Plan Corner

Instructions

Use the blank care plan at the bottom of the page to create your own plan.

<i>Altered/Alterations</i>	<i>Impaired/Impairment</i>	<i>General</i>
Bowel Elimination: Constipation	Adjustment	Activity Intolerance
Bowel Elimination: Diarrhea	Gas Exchange	Anxiety
Cardiac Output: Decreased	Home Maintenance Management	Coping: Ineffective Individual
Comfort: Chest Pain	Physical Mobility	Discharge
Comfort: Pain	Skin Integrity	Disuse Syndrome
Family Processes	Social Interaction	Diversional Activity Deficit
Growth and Development	Verbal Communication	Fear
Health Maintenance		Fluid Volume Deficit
Nutrition: Less than Body Requirements		Fluid Volume Excess
Nutrition: More than Body		Grieving
		Hyperthermia
		Hypothermia

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[Oral Mucous](#)

[Membranes: Stomatitis](#)

[Parenting](#)

[Sensory Perceptual](#)

[Sexuality Patterns](#)

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[Incontinence](#)

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Careplan Corner @ RN Central

Are you a student in need of some ideas for your care plans? Are you required to use standardized care plans at work and need some ideas? If you answered yes then this is the place for you! These are only *suggested*, pre-defined care plans. You may copy, save, print and modify them in any way you wish. If you have any suggestions for additions, please contact [RN Central!](#)

When you click on the links to the care plans , they will show up in a new window.

To print out the care plans:

Internet Explorer:

Right click inside the frame you want to print. Choose "*print*" from the pop up menu.

Netscape:

Click somewhere inside the frame you want to print. Go to "*File*" on your browser's top menu, select "*Print Frame*".

After printing your plan, close the new window.

Alteration in Bowel Elimination: Constipation

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Malnutrition <input type="checkbox"/> Metabolic and endocrine disorders <input type="checkbox"/> Sensory/motor disorders <input type="checkbox"/> Stress <input type="checkbox"/> Immobility <input type="checkbox"/> Inadequate diet <input type="checkbox"/> Irregular evacuation pattern	<input type="checkbox"/> Drug side effects <input type="checkbox"/> Pain (upon defecation) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Surgery <input type="checkbox"/> Lack of privacy <input type="checkbox"/> Dehydration <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Hard formed stool and/or defecation occurs fewer than three times per week.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Decreased bowel sounds. <input type="checkbox"/> Reported feeling of rectal fullness or pressure around rectum. <input type="checkbox"/> Straining and pain on defecation. <input type="checkbox"/> Palpable impaction.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[[Check those that apply]</i>	Date Achieved:

The patient will:

Have soft formed stool by _____ and q ____ day(s).

Patient and/or significant other will verbalize an understanding of method for preventing and/or treating constipation.

Assess abdomen for distention, bowel sounds q ____ hours.

Assess bowel elimination q ____ hours.

Assess factors responsible for constipation:

- stress
- discomfort
- sedentary lifestyle
- laxative abuse
- debilitation
- lack of time/privacy
- drug side effect

Promote corrective measures:

- review daily routine
- provide privacy/time
- provide comfort
- encourage adequate exercise

Promote adequate dietary/ fluid intake. Patient likes:

Fluids: _____

Fiber foods: _____

Initiate bowel program to promote defecation.

Consult dietitian.

Other: _____

Patient/Significant other signature

RN signature

Alteration in Bowel Elimination: Diarrhea

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Inflammation of bowels <input type="checkbox"/> Colon mucosa ulceration <input type="checkbox"/> Fecal impaction <input type="checkbox"/> Gastric bypass <input type="checkbox"/> Infant - breast fed <input type="checkbox"/> Decreased sphincter reflexes <input type="checkbox"/> Allergies	<input type="checkbox"/> Medications _____ _____ <input type="checkbox"/> Stress/anxiety <input type="checkbox"/> Tube feedings <input type="checkbox"/> Decreased tolerance to dietary program: _____ _____ <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Loose liquid stools and/or: <input type="checkbox"/> Frequency
Minor: <i>(May be present)</i>	<input type="checkbox"/> Urgency <input type="checkbox"/> Cramping/abdominal pain <input type="checkbox"/> Hyperactive bowel sounds <input type="checkbox"/> Increase of fluidity or volume of stools

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Have stool/elimination pattern that closer resembles that of patient's normal stool/pattern.

Patient and/or significant other will verbalize methods for preventing and/or treating diarrhea.

Other:

Assess abdomen for distention, bowel sounds, pain q___ hours.

Identify factors that contribute to diarrhea:_____

Record color, odor, amount and frequency of stool.

Instruct patient in:

- diet
- medication usage
- S/S of diarrhea to watch for requiring medical attention
- discontinuing solids
- offer clear liquids.

Other:_____

Patient/Significant other signature

RN signature

Alterations in Cardiac Output: Decreased

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Cardiac factors <input type="checkbox"/> Pulmonary disorders <input type="checkbox"/> Endocrine disorders <input type="checkbox"/> Hematological disorders <input type="checkbox"/> Fluid & electrolyte disturbances <input type="checkbox"/> Surgery/anesthesia <input type="checkbox"/> Newborn/Infant	<input type="checkbox"/> Vagal stimulation <input type="checkbox"/> Stress <input type="checkbox"/> Shock <input type="checkbox"/> Allergic response <input type="checkbox"/> Medications <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

<input type="checkbox"/> Angina <input type="checkbox"/> Cardiac arrhythmia <input type="checkbox"/> Cyanosis <input type="checkbox"/> Dyspnea <input type="checkbox"/> Edema (periph./sacral)	<input type="checkbox"/> Fatigability <input type="checkbox"/> Hypotention <input type="checkbox"/> Oliguria <input type="checkbox"/> Restlessness <input type="checkbox"/> Tachycardia
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Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Demonstrate improved cardiac output A.E.B.:

- vital signs within normal limits for patient. [BP ____] [P ____]
- color pink
- chest clear
- balanced I & O
- minimal or absent edema

Other:

Assess color, BP, pulse, respirations q ____ hours.

Listen to breath sounds q ____ hours.

Check for edema of feet, legs, and sacrum q ____ hours.

Daily weights at ____ a.m./p.m. using same scale.

Measure intake and output q 8 hours.

Organize care to maximize periods of uninterrupted rest. Needs _____ rest periods/day. (Specify):

Explore with patient potential etiological factors for decreased cardiac output and provide health teaching. (See Discharge Plan)

Other: _____

Discharge Plan: _____

Patient/Significant other signature

RN signature

Comfort: Chest Pain

Related To:

[Check those that apply]

<input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Unstable Angina <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Chest Trauma <input type="checkbox"/> Stress Anxiety	<input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Pulmonary, Myocardial contusion <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Person reports or demonstrates a discomfort.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Increased BP <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Dilated pupils <input type="checkbox"/> Restlessness <input type="checkbox"/> Facial mask of pain <input type="checkbox"/> Crying/moaning <input type="checkbox"/> Short of breath <input type="checkbox"/> Anxiety

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Verbalize relief/control of pain. <input type="checkbox"/> Verbalize causative factors associated with chest pain. <input type="checkbox"/> Other:		<input type="checkbox"/> Assess for causative factors associated: <ul style="list-style-type: none"> ● Activity ● Stress ● Eating ● Bowel elimination ● Previous angina attack ● Other: <input type="checkbox"/> Assess characterizing of chest pain. <ul style="list-style-type: none"> ● Location ● Intensity (Scale 1-10) 	

- Duration
- Quality
- Radiation

(_) Review history of previous pain experienced by patient and compare to current experience.

(_) Instruct patient to report pain immediately.

(_) Continuous EKG monitoring; note and record pattern during pain. Obtain STAT 12-lead EKG per policy for acute changes noted on continuous monitor.

(_) Provide a quiet, restful environment.

(_) As per physician order, administer IV analgesics in small increments until pain is relieved or maximum dose is achieved. Monitor BP during administration of pain meds. Assess pt. response to pain medication and notify physician if pain is not controlled or pt. experiences adverse reaction (decreased BP, HA, distress).

(_) Administer nitroglycerine as ordered by physician. Monitor as stated above.

(_) Titrate IV Nitro to achieve pain relief as ordered by physician. Monitor hemodynamic response to medication (BP, urine output).

(_) Administer supplemental oxygen as ordered by physician.

Assist with ADL's to reduce cardiac stressors.

Assist in eliminating causative factors as identified by patient assessment.

Other: _____

Patient/Significant other signature

RN signature

Alteration in Comfort: Pain

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Musculoskeletal disorder <input type="checkbox"/> Visceral disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Information <input type="checkbox"/> Trauma <input type="checkbox"/> Diagnostic test	<input type="checkbox"/> Immobility/improper positioning <input type="checkbox"/> Pressure points <input type="checkbox"/> Pregnancy <input type="checkbox"/> Fear <input type="checkbox"/> Anxiety/stress <input type="checkbox"/> Overactivity <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Pt. reports or demonstrates discomfort.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Autonomic response to acute pain: <ul style="list-style-type: none"> ● increased BP, P, R ● diaphoresis ● dilated pupils ● guarding ● facial mask of pain ● crying/moaning ● abdominal heaviness ● cutaneous irritation

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Experience relief of pain A.E. B.

- verbal reports of relief of pain
- less autonomic responses to pain

Other:

Asses characteristics of pain: location, severity on a scale of 1-10, type, frequency, precipitating factors, relief factors.

Eliminate factors that precipitate pain: eg.:

Offer analgesics q___ hrs prn (according to physician order).

Teach patient to request analgesics before pain becomes severe.

Explore non-pharmacological methods for reducing pain/ promoting comfort:

- back rubs
- slow rhythmic breathing
- repositioning
- diversional activities such as music, TV, etc.

Other: _____

Patient/Significant other signature

RN signature

Alteration in Family Processes

() Actual () Potential

Related To:

[Check those that apply]

() Illness of a family member: _____

() Loss/gain of family member due to: _____

() Change in family roles: _____

() Conflict: _____

() Financial crisis: _____

() Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Family system cannot or does not adapt constructively to crisis or family system cannot or does not communicate openly and effectively between family members.
Minor: <i>(May be present)</i>	() Family system cannot or does not: <ul style="list-style-type: none"> ● meet physical needs of all its members ● meet emotional needs of all its members ● meet spiritual needs of all its members ● express or accept a wide range of feelings ● seek or accept help appropriately

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The family member or patient will:

Frequently verbalize feelings to professional nurse and each other.

Maintain functional system of mutual support for each member.

Seek appropriate external resources when needed.

Other:

Assess causative and contributing factors.

Meet with patient/family to identify:

- strengths/weaknesses
- resources available
- needs
- priorities
- alternative arrangements
- Other:

Encourage verbalization of guilt, anger, hostility, etc. and subsequent recognition of these feelings to:

- nursing staff
- family members

Direct family to hospital/ community agencies:

- home health care
- nurse discharge planners
- social workers
- other:

Other: _____

Patient/Significant other signature

RN signature

Altered Growth and Development

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Acute illness <input type="checkbox"/> Prolonged pain <input type="checkbox"/> Chronic illness <input type="checkbox"/> Prolonged bedrest <input type="checkbox"/> Neglect/isolation	<input type="checkbox"/> Traction or casts <input type="checkbox"/> Separation from significant other <input type="checkbox"/> Parental knowledge deficit <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() _____ _____ _____
Minor: <i>(May be present)</i>	() _____ _____ _____

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The child/patient will: <input type="checkbox"/> Demonstrate an increase in personal, social, language, cognition, or motor activities appropriate to age group. Specify Behaviors:		<input type="checkbox"/> Assess present level of personal, social, cognitive and motor development. <input type="checkbox"/> Assess etiological factors for alteration in growth and development. <input type="checkbox"/> On admission, evaluate height and weight. <input type="checkbox"/> Daily weights at ___ a.m./p.m.	

using the same scale.

(_) Provide opportunities for child to meet age related developmental tasks such as:

1. _____
2. _____
3. _____
4. _____
5. _____

(_) Teach parents appropriate developmental tasks and parental guidance information such as:

1. _____
2. _____
3. _____
4. _____
5. _____

(_) Other: _____

Patient/Significant other signature

RN signature

Alteration in Health Maintenance

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Loss of independence <input type="checkbox"/> Changing support systems <input type="checkbox"/> Change in finances <input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Poor learning skills (illiteracy) <input type="checkbox"/> Crisis situation <input type="checkbox"/> Inadequate health practice <input type="checkbox"/> Substance abuses: _____ _____	<input type="checkbox"/> Lack of accessibility to health care services <input type="checkbox"/> Health beliefs <input type="checkbox"/> Religious beliefs <input type="checkbox"/> Cultural/folk beliefs <input type="checkbox"/> Alterations in self image <input type="checkbox"/> Age related conditions <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

<p>Major: <i>(Must be present)</i></p>	<input type="checkbox"/> Reports or demonstrates an unhealthy practice or life style. <input type="checkbox"/> Reckless driving of vehicle. <input type="checkbox"/> Substance abuse. <input type="checkbox"/> Overeating. <input type="checkbox"/> Reports or demonstrates frequent alterations in health. eg: _____
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Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Incorporate principles of health promotion into lifestyle:

Other:

Assess for factors that contribute to the promotion and maintenance of health or that result in alterations in health.

Provide pertinent information concerning screening for: breast cancer, BP, other:

Explore health promotion behaviors that patient is willing to incorporate into lifestyle.

Initiate health teaching and referrals as indicated:

- review daily health practices
- dental care
- food intake
- fluid intake
- exercise
- use of tobacco, alcohol, and drugs
- knowledge of safety practices, fire prevention, water safety, automobile safety, bicycle safety, and poison control
- other:

Other: _____

Patient/Significant other signature

RN signature

Alteration in Nutrition: Less Than Body Requirements

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Dysphagia caused by: _____ <input type="checkbox"/> Absorptive disorders <input type="checkbox"/> Anorexia <input type="checkbox"/> Allergy <input type="checkbox"/> Burns <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chemical dependence <input type="checkbox"/> Crash or fad diet <input type="checkbox"/> Depression	<input type="checkbox"/> Inability to obtain food <input type="checkbox"/> Infection <input type="checkbox"/> Lack of knowledge of adequate nutrition <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Social isolation <input type="checkbox"/> Stress <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Reported inadequate food intake less than recommended daily allowance with or without weight loss and/or actual or potential metabolic needs in excess of intake.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Weight 10% to 20% or more below ideal for height and frame. <input type="checkbox"/> Tachycardia on minimal exercise and bradycardia at rest. <input type="checkbox"/> Muscle weakness and tenderness. <input type="checkbox"/> Mental irritability or confusion. <input type="checkbox"/> Decreased serum albumin.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Experience adequate nutrition through oral intake.

Experience an increase in the amount or type of nutrients ingested.

Gain weight.

Other:

Assess and document patient's dietary history, patterns of ingestion, intolerance to foods.

Assess patient likes and dislikes. Inform dietary.

Teach techniques to maintain adequate nutritional intake and stimulate appetite:

- administer/instruct pt. on good oral hygiene before and after feedings
- maintain pleasant environment for patient

Determine proper denture fit and provide adhesive as necessary.

Increase social contact with meals by:

Plan care so that unpleasant/painful tests/tx's don't take place before meals.

Medicate pt. for pain 2 hrs before meals per physician's orders.

Consult with dietitian re:

- calorie count
- change in food consistency
- spacing meals
- provision of high caloric supplements
- provision of high protein supplementation

- food intolerances/ preferences
 - extra fluids on tray
 - dietetic teaching, food selection
 - therapeutic diet restrictions:
-

(_) Consult with PT/PT re:

- strengthening exercises
- prosthetic devices
- swallowing disorders

(_) Environmental support to improve intake:

- be sure pt. is alert and responsive before eating
- sit upright 60-90 degrees for 15-20 min. before, during & after eating
- decrease distractions
- demonstrate patience by providing specific directions until finished
- assure good mouth care

(_) Weigh patient q_____ at _____ a.m./p.m.

(_) Other: _____

Patient/Significant other signature

RN signature

Alteration in Nutrition: More Than Body Requirements

() Actual () Potential

Related To:

[Check those that apply]

() Altered satiety patterns
 () Medications (steroids)
 () Lack of knowledge
 () Decreased activity
 () Decreased metabolic needs
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Overweight (weigh 10% to 20% over ideal for height and frame). () Obese (weigh over 20% of ideal).
Minor: <i>(May be present)</i>	() Reported undesirable eating patterns. () Intake in excess of metabolic requirements. () Sedentary activity patterns.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Decrease total calories ingested.

Increase activity level.

Loose weight:
(_____ pounds by discharge).

Other:

Assess and document patient's dietary history, patterns of ingestion, activity patterns.

Discuss with patient potential causative factors for weight gain.

Assess motivation to correct overweight.

Consult with dietician regarding balanced plan for weight loss. Reinforce teaching. Discuss realistic weight loss of not more than 2 pounds per week.

Provide positive reinforcement for weight loss.

Record intake.

Weigh q ____ days at _____ am/
pm.

Other: _____

Patient/Significant other signature

RN signature

Impaired Adjustment

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Illness <input type="checkbox"/> Other: _____ _____ _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Verbalization of non-acceptance of health status change. <input type="checkbox"/> Inability to be involved in problem solving or goal setting.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Lack of movement toward independence. <input type="checkbox"/> Extended period of shock, disbelief, or anger regarding health status change. <input type="checkbox"/> Lack of future oriented thinking.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Identify the temporary and long term demands of the situation. <input type="checkbox"/> Differentiate coping behavior that is effective vs. ineffective. <input type="checkbox"/> Other:		<input type="checkbox"/> Asses the patient's: <ul style="list-style-type: none"> ● pre-morbid lifestyle ● pre-morbid coping style ● amount and type of resources available ● extent of current disruption on life style ● current level of stress ● current coping methods and their effectiveness <input type="checkbox"/> Assist patient to identify the stressors.	

(_) Explore feelings about situation with patient.

(_) Identify factors that interfere with or delay effective adjustment:

- unmanageable level of stress
- ineffective problem solving
- inadequate or unavailable resources
- significant other(s)
- inadequate coping mechanisms
- explore effective coping mechanisms

(_) Other: _____

Patient/Significant other signature

RN signature

Impaired Gas Exchange

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Anesthesia <input type="checkbox"/> Allergic response <input type="checkbox"/> Altered level of consciousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Aspiration <input type="checkbox"/> Decreased lung compliance <input type="checkbox"/> Edema of tonsils, adenoids, sinuses <input type="checkbox"/> Excessive or thick secretions <input type="checkbox"/> Fear <input type="checkbox"/> Immobility <input type="checkbox"/> Improper positioning	<input type="checkbox"/> Infection <input type="checkbox"/> Loss of lung elasticity <input type="checkbox"/> Medication <input type="checkbox"/> Neuromuscular impairment <input type="checkbox"/> Obstruction <input type="checkbox"/> Pain <input type="checkbox"/> Smoking <input type="checkbox"/> Surgery <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Dyspnea on exertion.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Tendency to assume a three-point position (bending forward while supporting self by placing one hand on each knee). <input type="checkbox"/> Pursed lip breathing with prolonged expiratory phase. <input type="checkbox"/> Increased anteroposterior chest diameter, if chronic. <input type="checkbox"/> Lethargy and fatigue. <input type="checkbox"/> Increased pulmonary vascular resistance (increased pulmonary artery/right ventricular pressure). <input type="checkbox"/> Decreased oxygen content, decreased oxygen saturation, increased PCO ₂ . <input type="checkbox"/> Cyanosis.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Demonstrate optimal gas exchange as permitted by clinical condition A.E.B.:

- absence of cyanosis
- ABG's are within acceptable limits.

Other:

Assess color, respiratory rate and depth, effort, rythm q____.

Check for breath sounds q____.

Report ABG's that deviate from patient's baseline.

Position to facilitate optimum breathing patterns:

- HOB elevated ____ deg.
- turn q____ hrs.
- other:

Cough and deep breath.

Suction q____ hrs.

Increase actibity as tolerated to facilitate diaphragm excursion. eg:

Encourage fluid intake to decrease viscosity of secretions (when indicated).

Explore with patient potential etiological factors contributing to impaired gas exchange and provide appropriate health teaching. (Discharge Plan)

Other: _____

Patient/Significant other signature

RN signature

Impaired Home Maintenance Management

(_)Actual () Potential

Related To:

[Check those that apply]

Chronic debilitating disease: <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy	Injury to individual or family members: <input type="checkbox"/> Addition of family member <input type="checkbox"/> Loss of family member <input type="checkbox"/> Impaired mental status <input type="checkbox"/> Insufficient finances <input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Substance abuse <input type="checkbox"/> Surgery <input type="checkbox"/> Unavailable support system <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Outward expressions by individual or family of difficulty in maintaining the home or in caring for self or family members.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Poor hygiene practice. <input type="checkbox"/> Unwashed cooking/eating utensils. <input type="checkbox"/> Impaired caregiver. <input type="checkbox"/> Inadequate support system.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient or caregiver will:

Identify factors that restrict self care and home management.

Demonstrate the ability to perform skills necessary for the care of the individual or home.

Express satisfaction with home.

Other:

Assess for factors that might impair home management.

Explore with patient and/or significant other, factors that will facilitate home management and provide appropriate health teaching. (See Discharge Plan)

Procure necessary equipment or aids: _____

Refer to/consult with appropriate agencies for:

- insufficient funds:
- cooking:
- transportation:
- housework:
- home maintenance:
- other:

Other: _____

Patient/Significant other signature

RN signature

Impaired Physical Mobility

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Amputation <input type="checkbox"/> Cardiovascular <input type="checkbox"/> External devices <input type="checkbox"/> Impaired balance <input type="checkbox"/> Limited ROM <input type="checkbox"/> Musculoskeletal impairment	<input type="checkbox"/> Neuromuscular impairment <input type="checkbox"/> Pain <input type="checkbox"/> Surgical procedure <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Inability to move purposefully within the environment, including bed mobility, transfers, and ambulation.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Range of motion limitations. <input type="checkbox"/> Limited muscle strength or control. <input type="checkbox"/> Impaired coordination.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Maintain or increase strength and endurance of upper/lower limbs A.E.B.: <input type="checkbox"/> Will not develop complications of immobility. <input type="checkbox"/> Demonstrate use of adaptive		<input type="checkbox"/> Assess symmetry, strength, and degree of mobility. <input type="checkbox"/> Passive/active ROM exercises as ordered by physician q_____ to:_____ (body part). <input type="checkbox"/> Position in proper alignment and reposition q_____ hrs. <input type="checkbox"/> Encourage isometric	

device(s) to increase mobility.

Device:

(_) Other:

exercises when indicated.

(_) Up in chair _____ minutes
q_____.

(_) Check/teach proper use/
function of adaptive equipment.

(_) Provide progressive
mobilization.

(_) Referral:

- PT
- OT
- other:

(_) Other: _____

Patient/Significant other signature

RN signature

Impaired Skin Integrity

() Actual () Potential

Related To:

[Check those that apply]

() Burns of _____

() Decreased sensation

() Immobility

() Malnutrition

() Pressure ulcer

() Puritus

() Stoma problems

() Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Disruption of epidermal and dermal tissue.
Minor: <i>(May be present)</i>	() Denuded skin. () Erythema. () Lesions. Other: _____

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

() Maintain or develop clean and intact skin.

() Other:

() Inspect and chart skin integrity q_____hrs.

() Do wound care/dressing change as ordered. Describe:

() Provide measures to decrease pressure/irritation to skin:

- fleece pad
- egg crate mattress
- keep skin clean and dry
- other:

() Turn and reposition q_____hrs.

() Up in chair for ___ minutes q_____.

() Gently massage bony prominences and pressure points with lotion q_____.

() Maintain adequate nutrition and hydration.

() Change incontinent pad ASAP after voiding or defecation.

() Expose skin to air if indicated.

() Initiate health teaching and referrals as indicated. List:

Keep nails short.

Mittens to decrease skin breakdown from scratching. (These are considered a restraint in some facilities. Get an order first.)

Change ostomy appliance prn when leaking.

Other: _____

Patient/Significant other signature

RN signature

Impaired Social Interaction

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Mental illness <input type="checkbox"/> Other: _____ _____ _____
--

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Reports inability to establish and/or maintain stable, supportive relationships.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Lack of motivation. <input type="checkbox"/> Severe anxiety. <input type="checkbox"/> Dependent behavior. <input type="checkbox"/> Hopelessness. <input type="checkbox"/> Delusions/hallucinations. <input type="checkbox"/> Disorganized thinking. <input type="checkbox"/> Lack of self care skills. <input type="checkbox"/> Poor impulse control. <input type="checkbox"/> Distractibility/inability to concentrate. <input type="checkbox"/> Social isolation. <input type="checkbox"/> Superficial relationships. <input type="checkbox"/> Difficulty holding a job. <input type="checkbox"/> Lack of self esteem.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Identify problematic behavior that deters socialization.

Describe and utilize strategies to promote effective socialization.

Other:

Assess patients feelings relative to social isolation.

Help to identify precipitating factor(s)/stressors.

Help to identify alternative courses of action.

Assist in analyzing approaches which work best.

Provide supportive group therapy when indicated.

Encourage to validate perception with others.

Identify strengths and areas of improvement.

Role model certain accepted social behaviors: _____

Hold accountable for own actions.

Other: _____

Patient/Significant other signature

RN signature

Impaired Verbal Communication

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Auditory impairment <input type="checkbox"/> Cerebral impairment <input type="checkbox"/> Fear/shyness <input type="checkbox"/> Lack of privacy <input type="checkbox"/> Lack of support system <input type="checkbox"/> Language barrier <input type="checkbox"/> Laryngeal edema/infection	<input type="checkbox"/> Neurologic impairment <input type="checkbox"/> Oral deformities <input type="checkbox"/> Pain <input type="checkbox"/> Respiratory impairment <input type="checkbox"/> Speech pathology <input type="checkbox"/> Surgery <input type="checkbox"/> Other: _____ _____ _____
---	---

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Inappropriate or absent speech or response.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Stuttering. <input type="checkbox"/> Slurring. <input type="checkbox"/> Problem in finding the correct words when speaking. <input type="checkbox"/> Weak or absent voice. <input type="checkbox"/> Decreased auditory comprehension. <input type="checkbox"/> Deafness or inattention to noises or voices. <input type="checkbox"/> Confusion. <input type="checkbox"/> Inability to speak the dominant language of culture.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Demonstrate improved ability to express self A.E.B.:

Relate findings of decreased frustration and isolation with communication.

Other:

Assess type of impairment.

Decrease environmental stimuli.

Be cognizant of possible cultural barriers.

Offer alternative forms of communication such as:

- gestures or actions
- pictures or drawings
- magic slate
- word board
- flash cards that translate words/phrases

Encourage s/o to participate.

Validate patient's message by repeating aloud.

Use short repetitive directions.

Ask simple yes or no questions.

Speak on an adult level, speaking clearly and slower than normal.

Assess frustration level. Wait 30 seconds before providing patient with word.

Initiate health teaching.

Referrals:

- Translator
- Speech Pathologist.
- Psychiatry
- Other:

(_) Other: _____

Patient/Significant other signature

RN signature

Activity Intolerance

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Alterations in O2 transport <input type="checkbox"/> Chronic disease: _____ <hr/> <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Fatigue <input type="checkbox"/> Lack of motivation <input type="checkbox"/> Malnourishment	<input type="checkbox"/> Pain <input type="checkbox"/> Prolonged immobility <input type="checkbox"/> Stressors <input type="checkbox"/> Other: _____ <hr/> <hr/>
--	--

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> _____ <hr/> <hr/>
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Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Identify factors that reduce activity tolerance. <input type="checkbox"/> Progress to highest level of mobility possible. Describe: <input type="checkbox"/> Exhibit a decrease in anoxic		<input type="checkbox"/> Reduce or eliminate contributing factors by: <ul style="list-style-type: none"> ● Assess patient's schedule. Allow rest periods between all activities. ● Encourage person to note daily progress. ● Evaluate patient's pain and the present treatment regimen. ● Check pulse rates resting and after activity to avoid 	

signs of increased activity. (eg: BP, pulse, resp.)

() Other:

danger of too great an increase.

- Assess skin color (hands, nails, circumoral) before and after activity.
- Relaxation training (work with pulmonary rehab.)
- Cough/deep breathe.
- Encourage fluid intake, roughage.
- Teach inhaler use.
- Sit when conversing with patient.
- Progress the activity gradually.

() Other: _____

Patient/Significant other signature

RN signature

Anxiety

(_)Actual () Potential

Related To:

[Check those that apply]

- | |
|--|
| <input type="checkbox"/> Anesthesia
<input type="checkbox"/> Anticipated/actual pain
<input type="checkbox"/> Disease
<input type="checkbox"/> Invasive/noninvasive procedure: _____
<hr/> <input type="checkbox"/> Loss of significant other
<input type="checkbox"/> Threat to self-concept
<input type="checkbox"/> Other: _____
<hr/> <hr/> |
|--|

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	[Physiological] <input type="checkbox"/> Elevated BP, P, R <input type="checkbox"/> Insomnia <input type="checkbox"/> Restlessness <input type="checkbox"/> Dry mouth <input type="checkbox"/> Dilated pupils <input type="checkbox"/> Frequent urination <input type="checkbox"/> Diarrhea [Emotional] <input type="checkbox"/> Patient complains of apprehension, nervousness, tension [Cognitive] <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Orientation to past <input type="checkbox"/> Blocking of thoughts, hyperattentiveness
---	---

**Date &
Sign.**

Plan and Outcome
[Check those that apply]

**Target
Date:**

Nursing Interventions
[Check those that apply]

**Date
Achieved:**

The patient will:

Demonstrate a decrease in anxiety A.E.B.:

- A reduction in presenting physiological, emotional, and/or cognitive manifestations of anxiety.
- Verbalization of relief of anxiety.

Discuss/demonstrate effective coping mechanisms for dealing with anxiety.

Other:

Assist patient to reduce present level of anxiety by:

- Provide reassurance and comfort.
 - Stay with person.
 - Don't make demands or request any decisions.
 - Speak slowly and calmly.
 - Attend to physical symptoms. Describe symptoms:
-
- Give clear, concise explanations regarding impending procedures.
 - Focus on present situation.
 - Identify and reinforce coping strategies patient has used in the past.
 - Discuss advantages and disadvantages of existing coping methods.
 - Discuss alternate strategies for handling anxiety. (Eg.: exercise, relaxation techniques and exercises, stress management classes, directed conversation (by nurse), assertiveness training)
 - Set limits on manipulation or irrational demands.
 - Help establish short term goals that can be attained.
 - Reinforce positive responses.
 - Initiate health teaching and referrals as indicated:

() Other: _____

Patient/Significant other signature

RN signature

Ineffective Individual Coping

(_)Actual () Potential

Related To:

[Check those that apply]

(_) Illness: _____

(_) Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Change in usual communication patterns (in acute). <input type="checkbox"/> Verbalization of inability to cope. <input type="checkbox"/> Inappropriate use of defense mechanisms. <input type="checkbox"/> Inability to meet role expectations.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Anxiety () Reported life stress. () Inability to problem-solve. <input type="checkbox"/> Alteration in social participation. () Destructive behavior toward self or others. <input type="checkbox"/> High incidence of accidents. () Frequent illnesses. <input type="checkbox"/> Verbalization of inability to ask for help. () Verbal manipulation. <input type="checkbox"/> Inability to meet basic needs.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Verbalize feelings related to emotional state.

Identify individual strengths.

Identify coping mechanisms (new and old).

Utilize effective coping mechanisms as evidenced by:

Other:

Encourage verbalization of feelings, perceptions, and fears.

Assist to set realistic goals.

Encourage independence by:

Assist with identification of potential solutions to present problems.

Consult with:

- Pastoral care
- Social services
- Psych services
- Other:

Identify problems that cannot be controlled.

Other: _____

Patient/Significant other signature

RN signature

Discharge Care Plan

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	<p>(<input type="checkbox"/>) The patient/family's discharge planning will begin on day of admission including preparation for education and/or equipment.</p> <p>(<input type="checkbox"/>) On the day of discharge, patient/family will receive verbal and written instructions concerning:</p> <ul style="list-style-type: none"> ● Medications ● diet ● Activity ● Treatments ● Follow up appointments ● Signs and symptoms to observe for (when to contact the doctor) ● Care of incisions, wounds, etc. <p>(<input type="checkbox"/>) Other:</p>		<p>(<input type="checkbox"/>) Assess needs of patient/family beginning on the day of admission and continue assessment during hospitalization.</p> <p>(<input type="checkbox"/>) Anticipated needs/services:</p> <ul style="list-style-type: none"> ● Respiratory equipment ● Hospital bed ● Wheel char ● Walker ● Home health nurse ● Home PT/OT/ST <p>(<input type="checkbox"/>) Involve the patient/family in the discharge process.</p> <p>(<input type="checkbox"/>) Discuss with physician the discharge plan and obtain orders if needed.</p> <p>(<input type="checkbox"/>) Contact appropriate personnel with orders.</p> <p>(<input type="checkbox"/>) Provide written and verbal instructions at the patient/family's level of understanding.</p> <p>(<input type="checkbox"/>) Verbally explain instructions to patient/family prior to discharge and provide patient/family with a written copy.</p> <p>(<input type="checkbox"/>) Ascertain that patient has follow-up care arranged at discharge.</p>	

Provide verbal and written information on what signs and symptoms to observe and when to contact the physician.

Assess if any community resources should be utilized (i.e.: Home Health Nurse), and contact appropriate personnel.

Document all discharge teaching on Discharge Instruction Sheet and Nursing notes.

Other: _____

Patient/Significant other signature

RN signature

Disuse Syndrome

() Actual () Potential

Related To:

[Check those that apply]

() Unconsciousness
 () Neuromuscular Impairment
 () Musculoskeletal condition
 () Immobility
 () Traction/casts/splints
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Presence of risk factors. (See above "Related To").
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Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: () Maintain or regain free range of motion of extremities within limits of disease. () Maintain or regain function of: _____ _____ within limits of disease. () Other:		() Assess range of motion of affected extremities and the ability of patient to perform ADL's. () Consult with PT/OT regarding necessary exercises/assistive devices. () Range of motion to _____ extremities _____ times a day. () Splints to _____ . Apply	

during _____. Remove for

_____.

(_) Other: _____

Patient/Significant other signature

RN signature

Diversional Activity Deficit

() Actual () Potential

Related To:

[Check those that apply]

() Monotonous environment
 () Long-term hospitalization
 () Lack of motivation with signs of depression
 () Skeletal-muscular impairments
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Observed statement of boredom/depression fro inactivity.
Minor: <i>(May be present)</i>	() Constant expression of unpleasant thoughts or feelings. () Yawning or inattentiveness. () Flat facial expression. () Restlessnes/fidgeting. () Body language (shifting of body away from speaker). () Immobile (on bed rest or confined). () Weight loss or gain. () Hostility.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Recognize feelings of boredom and discuss methods of finding diversional activities.

Engage in group or individual diversional activity.

State satisfaction with use of one's time.

Other:

Assess causative factors:

- Monotony
- Inability to make decisions
- Diminished socialization.
- Lack of motivation

Obtain an activity assessment (find our hobbies, likes and dislikes):

Assist in selection of an activity that is seen as having value and importance:

Include above activity in daily routine of care.

Involve patient in own care by:

Increase environmental stimulation of sight and sound by:

Consult wiith other departments:

- Pastoral care
- Occupational therapy
- Volunteers

Other:_____

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Patient/Significant other signature

RN signature

Fear

() Actual () Potential

Related To:

[Check those that apply]

() Invasive procedures
 () Hospitalization
 () Loss of s/o
 () Pain
 () Anesthesia
 () Surgery
 () Disability/chronic/acute/terminal illness:

() Lack of knowledge: _____

() Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Feelings of dread, fright, apprehension and/or behaviors of avoidance. () Narrowing of focus on danger. () Deficits in attention, performance, and control.
Minor: <i>(May be present)</i>	() Verbal reports of panic. () Obsessions - acts of aggression, escape, hypervigilance, dysfunctional immobility, compulsive mannerisms, increased questioning/verbalization. () Visceral-somatic activity: Musculoskeletal (muscle tightness, fatigue), cardiovascular (palpitations, rapid pulse, increased blood pressure), respiratory (shortness of breath, increased rate), gastrointestinal (anorexia, nausea/vomiting, diarrhea), Genitourinary (urinary frequency), skin (flush/pallor, sweating, paresthesia) CNS/perceptual (syncope, insomnia, lack of concentration, irritability, absentmindedness, nightmares, dilated pupils).

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
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The patient will:

Discuss his/her fears.

Differentiate real from imagined situations.

Identify his/her own coping responses.

Recognize effective and ineffective coping patterns.

Experience increase in psychological and physiological comfort as evidenced by:

Other:

Assess possible contributing factors.

Reduce or eliminate contributing factors by:

- Orient to environment using simple explanations.
- Speak slowly and calmly.
- Avoid surprises and painful stimulus.
- Use familiar routine.

Allow personal space.

Remain with person until fear subsides.

Utilize family members and s/o to stay with him/her.

Encourage expression of feelings.

Refocus interaction on areas of capability rather than dysfunction.

Encourage patient to face the fear.

Provide information to reduce distortions.

Age related fears:

- Provide child opportunities to express fears.
- Acknowledge illness, death, pain as real.
- Encourage open, honest sharing.
- Discuss with parents the normalcy of fear in

children.

(_) Provide or demonstrate methods that increase comfort or relaxation:

- Progressive relaxation techniques.
- Reading, music, breathing exercises.
- Thought stopping, guided fantasy.

(_) Other: _____

Patient/Significant other signature

RN signature

Fluid Volume Deficit

() Actual () Potential

Related To:

[Check those that apply]

() Excessive urinary output.
 () Inadequate fluid intake.
 () Abnormal drainage.
 () Excessive emesis.
 () Difficulty in swallowing.
 () Medication: _____
 () Diarrhea () Shock () Hemorrhage () Fever () Burns
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Output greater than intake. () Dry skin/mucous membranes.
Minor: <i>(May be present)</i>	() Increased serum sodium. () Increased pulse from baseline. () Decreased or excessive urine output. () Concentrated urine. () Urinary frequency. () Decreased fluid intake. () Poor skin turgor. () Thirst/nausea/anorexia.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

(_) Demonstrate adequate fluid balance A.E.B.:

- Moist mucous membranes.
- Balanced intake and output.
- Normal lab values.
- Improved skin turgor.

(_) Other:

(_) Asses:

- Moistness of mucous membrane and skin turgor and chart findings.
- Intake and output q____ hours.
- Orthostatic hypotension QD.
- Daily weights each _____ am/pm using same scale.
- Labs: HCT, BUN, Specific gravity, Sodium, Other: _____

(_) Encourage fluid intake of _____ cc/day; _____.

(_) Assist patient with drinking if necessary.

(_) Explore patient's understanding of etiological factors and provide necessary teaching.

(_) Other: _____

Patient/Significant other signature

RN signature

Fluid Volume Excess

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Decreased cardiac output <input type="checkbox"/> Low protein intake <input type="checkbox"/> Liver disease <input type="checkbox"/> Inflammatory process <input type="checkbox"/> Steroid therapy	<input type="checkbox"/> Medications: _____ <input type="checkbox"/> Excess fluid intake <input type="checkbox"/> Sodium intake more than adequate <input type="checkbox"/> Other: _____ _____ _____
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As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Edema <input type="checkbox"/> Taught, shiny skin
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Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Have decreased edema in extremities. <input type="checkbox"/> Other:		<input type="checkbox"/> Reduce or eliminate causative contributing factors: _____ _____ <input type="checkbox"/> Assess location and severity of edema q ____ hours. <input type="checkbox"/> Measure intake and output. <input type="checkbox"/> Measure edematous extremity (ies) or abdominal girth q ____. <input type="checkbox"/> Daily weights each ____ am/pm using same scale.	

Elevate _____ extremity
(ies) _____ degrees.

Passive/active range of
motion exercises of _____ q
_____ hours.

Avoid constrictive clothing.

Explore with patient potential
etiological factors for edema and
provide health teaching.

Other: _____

Patient/Significant other signature

RN signature

Grieving

() Actual () Potential

Related To:

[Check those that apply]

() Loss of function of body part: _____

() Loss of s/o: _____

() Loss of independence/change in lifestyle.

() Diagnosis of a terminal illness.

() Loss of physical abilities: _____

() Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Unsuccessful adaptation to loss <input type="checkbox"/> Expressed distress of actual or potential loss <input type="checkbox"/> Prolonged denial <input type="checkbox"/> Depression <input type="checkbox"/> Delayed emotional reaction
Minor: <i>(May be present)</i>	<input type="checkbox"/> Social isolation or withdrawal <input type="checkbox"/> Failure to develop new relationships/interests <input type="checkbox"/> Failure to restructure life after a loss <input type="checkbox"/> Denial <input type="checkbox"/> Guilt <input type="checkbox"/> Anger <input type="checkbox"/> Sorrow <input type="checkbox"/> Change in eating habits <input type="checkbox"/> Change in sleep patterns <input type="checkbox"/> Decreased libido <input type="checkbox"/> Change in communication patterns

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Express his/her grief.

Describe the meaning of the death or loss to him/her.

Share his/her grief with s/o.

Participate in ADL's as tolerated.

Other:

Assess for causative and contributing factors that may delay the grief process:

Reduce or eliminate causative or contributing factors if possible.

Encourage to recognize grief situation.

Give opportunity for questions.

Encourage expressions of anger/concerns.

Describe the stages of anticipatory grieving. (Include s. o).

Have patient identify support systems.

Assist with unfinished business.

Encourage to share prognosis with s/o.

Encourage s/o to participate in care.

Encourage problem solving with help of others.

Encourage planned, "one day at a time" living.

Allow patient opportunity to identify own self care needs:

		<hr/> <hr/> <p>(_) Help to set realistic goals - give realistic hope:</p> <hr/> <hr/> <p>(_) Encourage patient and s/o to accept individual responses to impending loss.</p> <p>(_) Refer/order consult:</p> <ul style="list-style-type: none">● Pastoral care● Social services● Home health care● Psychiatry <p>(_) Other: _____</p> <hr/> <hr/> <hr/>	
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Patient/Significant other signature

RN signature

Hyperthermia

(_) Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> CNS Pathology	<input type="checkbox"/> Inflammation
<input type="checkbox"/> Dehydration	<input type="checkbox"/> Peripheral neuropathy related to injury
<input type="checkbox"/> Exposure to heat/sun	<input type="checkbox"/> Vigorous activity
<input type="checkbox"/> Impaired physical environment	Other: _____
<input type="checkbox"/> Infection	_____

As evidenced by:

[Check those that apply]

Major: (Must be present)	<input type="checkbox"/> Temperature over 37.8 C (100 F) orally, or 38.8 C (101 F) rectally.
Minor: (May be present)	<input type="checkbox"/> Flushed skin <input type="checkbox"/> Warm to touch <input type="checkbox"/> Increased respiratory rate <input type="checkbox"/> Tachycardia <input type="checkbox"/> Shivering/goose pimples <input type="checkbox"/> Dehydration <input type="checkbox"/> Malaise/weakness <input type="checkbox"/> Loss of appetite

Date & Sign.	Plan and Outcome [Check those that apply]	Target Date:	Nursing Interventions [Check those that apply]	Date Achieved:
	The patient will: <input type="checkbox"/> Maintain normal body temperature. <input type="checkbox"/> Other:		<input type="checkbox"/> Assess temperature q ____ hours. <input type="checkbox"/> Assess possible etiology of increased temperature. <input type="checkbox"/> Encourage fluids when indicated. <input type="checkbox"/> Administer antipyretics per physician's order. <input type="checkbox"/> Remove excess clothing or	

blankets.

Provide air condition/fan if appropriate.

Other: _____

Patient/Significant other signature

RN signature

Hypothermia

(_) Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> CNS pathology <input type="checkbox"/> Decreased ability to shiver <input type="checkbox"/> Exposure to the cold <input type="checkbox"/> Impaired physical environment <input type="checkbox"/> Other: _____ _____ _____
--

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Reduction in body temperature below 35 C (95 F) orally, or 35.5 C (96 F) rectally. <input type="checkbox"/> Cool skin () Moderate pallor () Shivering (mild)
Minor: <i>(May be present)</i>	<input type="checkbox"/> Mental confusion/drowsiness/restlessness <input type="checkbox"/> Decreased pulse and respirations () Cachexia/malnutrition

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Maintain normal body temperature. Other:		<input type="checkbox"/> Assess temperature q ____ hours. <input type="checkbox"/> Asses for possible etiology of hypothermia. <input type="checkbox"/> Keep room temperature between 70-74 F. <input type="checkbox"/> Aply extra blankets. <input type="checkbox"/> Use warming blanket per physician's order to maintain	

normal body temperature.

Provide intravenous solutions through a blood warmer per physician's order.

Rewarm patient gradually to prevent complications of rapid rewarming.

Teach patient to avoid extremes of cold weather and to dress adequately when exposed to cold.

Other: _____

Patient/Significant other signature

RN signature

Altered Oral Mucous Membranes: Stomatitis

() Actual () Potential

Related To:

[Check those that apply]

() Immunosuppression from chemotherapy
 () Nutritional depletion
 () Radiation to head and neck
 () Improper fitting dentures
 () Excessive dry mouth
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Disruption of mucous membrane tissue. () Lesion
Minor: <i>(May be present)</i>	() Coated tongue () Dry mucous membranes () Edema () Erythema () Leukoplakia

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Be free of oral mucosa irritation.

Exhibit signs of healing with decrease inflammation.

Other:

Obtain history of radiation or chemotherapy regimen.

Check for oral burning, pain, or change in tolerance to temperature.

Do oral exam noting evidence of lesions within the mouth and tongue q_____.

Oral hygiene q_____ hours using:

Teach patient to:

- avoid commercial mouth washes, citrus fruit juices, spicy foods, extremes in food temperature, crusty or rough foods
- use straw to facilitate fluids bypassing inflamed lesions (if indicated)
- use soft tooth brush or toothettes for oral care
- check for proper fit of dentures

Other: _____

Patient/Significant other signature

RN signature

Alteration in Parenting

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Abusive <input type="checkbox"/> Accident victim <input type="checkbox"/> Acutely disabled <input type="checkbox"/> Addicted to drugs <input type="checkbox"/> Adolescent <input type="checkbox"/> Alcoholic <input type="checkbox"/> Breastfeeding difficulties <input type="checkbox"/> Change in family unit <input type="checkbox"/> Economic problems	<input type="checkbox"/> Emotionally disturbed <input type="checkbox"/> Lack of extended family <input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Relationship problems <input type="checkbox"/> Separation from nuclear family <input type="checkbox"/> Single parent <input type="checkbox"/> Terminally ill <input type="checkbox"/> Unrealistic expectations of self, infant, partner <input type="checkbox"/> Other: _____ _____ _____
---	---

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Inappropriate parenting behaviors. <input type="checkbox"/> Lack of parental attachment behavior.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Frequent verbalization of dissatisfaction or disappointment with infant/child. <input type="checkbox"/> Verbalization of frustration of role. <input type="checkbox"/> Verbalization of perceived or actual inadequacy. <input type="checkbox"/> Diminished or inappropriate visual, tactile, or auditory stimulation. <input type="checkbox"/> Evidence of abuse or neglect of child. <input type="checkbox"/> Growth and development lag in infant/child.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Begin to verbalize positive feelings re: child, self.

Demonstrate increased attachment behaviors such as holding infant close, talking to infant, eye contact.

Initiate active role in child's care.

Identify activities that defer and promote successful breast feeding.

Identify outside resources for support/guidance:

Demonstrate ability to care for infant.

Identify support system.

Other:

Assess causative or contributing factors.

Eliminate/reduce contributing factors.

Promote ongoing attachment process by: _____

Assist to identify and contact appropriate outside resources.

Will assist patient to identify support system and assess strengths and weaknesses.

Provide support to parents/ support system by: _____

Provide interventions that promote parents and s/o self esteem.

Counsel the parent(s) on assessed needs.

Consult with: _____

Encourage mother/father to feed, diaper, dress, bathe child.

Promote successful breastfeeding by:

- proper positioning
- eye to eye contact
- feeding on demand
- encourage rooming in

- proper latching on of infant to breast
- other

(_) Other: _____

Patient/Significant other signature

RN signature

Alteration in Sensory Perceptual

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Amputation <input type="checkbox"/> Bedrest <input type="checkbox"/> Cast <input type="checkbox"/> Hearing <input type="checkbox"/> Immobility <input type="checkbox"/> Impaired oxygen transport <input type="checkbox"/> Medications <input type="checkbox"/> Metabolic alterations <input type="checkbox"/> Neurological alterations <input type="checkbox"/> Pain	<input type="checkbox"/> Paraplegia <input type="checkbox"/> Physical isolation <input type="checkbox"/> Social isolation <input type="checkbox"/> Stress <input type="checkbox"/> Traction <input type="checkbox"/> Visual <input type="checkbox"/> Other: _____ _____ _____
---	---

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Inaccurate interpretation of environmental stimuli. <input type="checkbox"/> Negative change in amount or pattern of incoming stimuli.
Minor: <i>(May be present)</i>	<input type="checkbox"/> Disoriented about person, place, or time. <input type="checkbox"/> Altered problem solving ability. <input type="checkbox"/> Altered behavior or communication pattern. <input type="checkbox"/> Sleep pattern disturbances. <input type="checkbox"/> Restlessness. <input type="checkbox"/> Reports auditory or visual hallucinations. <input type="checkbox"/> Fear. <input type="checkbox"/> Anxiety. <input type="checkbox"/> Apathy.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Demonstrate optimal contact with reality.

Demonstrate an increase in self care activities.

Experience decreased symptoms of sensory overload.

Other:

Assess ability of patient to accurately interpret sensory stimuli.

Monitor electrolytes, adequacy of BP.

Organize nursing care to provide uninterrupted sleep at night.

Reduce unessential stimuli, if possible. Orient to person, place, and time with every nurse/patient contact.

Encourage interaction with familiar persons.

Explain all nursing care.

Other: _____

Patient/Significant other signature

RN signature

Altered Sexuality Patterns

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Cardiac disease <input type="checkbox"/> Chronich respiratory disease <input type="checkbox"/> Medication <input type="checkbox"/> Metabolic disease <input type="checkbox"/> Neurological disease	<input type="checkbox"/> Penile prosthesis <input type="checkbox"/> Prostatectomy <input type="checkbox"/> Other: _____ _____ _____
---	---

As evidenced by:

[Check those that apply]

Major: (Must be present)	<input type="checkbox"/> Identification of sexual difficulties, limitations, or changes.
------------------------------------	--

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Experience sexual pleasure as defined by self and partner. <input type="checkbox"/> Learn alternative ways of sexual expresiion. <input type="checkbox"/> Other:		<input type="checkbox"/> Assess patient's current satisfaction with sexual functioning. <input type="checkbox"/> Discuss with patient potential etiological factors for a change in sexual functioning. <input type="checkbox"/> Teach patient necessary information regarding implantable devices. eg. penile prosthesis. <input type="checkbox"/> Referral to: _____ _____ _____	

(_) Other: _____

Patient/Significant other signature

RN signature

Alteration in Thought Processes

(Geriatrics)

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Factors associated with aging. <input type="checkbox"/> Other: _____ _____ _____
--

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Inaccurate interpretation of stimuli, internal and/or external.
Minor: <i>(May be present)</i>	() Cognitive defects, including abstraction, memory, suspiciousness, delusions, hallucinations, distractibility, lack of consensual validation, language, confusion/disorientation.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Demonstrate optimum contact with reality. <input type="checkbox"/> Demonstrate an increase in self-care activities. <input type="checkbox"/> Other:		<input type="checkbox"/> Assess for etiological and contributing factors: <ul style="list-style-type: none"> ● physiological ● situational <input type="checkbox"/> Assess history of confusion (onset/duration). <input type="checkbox"/> Determine the amount and type of stimuli needed by the patient in the context of his/her usual life style.	

(_) Promote communication and sensory input.

(_) Promote a well role:

- encourage ADL's per patient as much as possible
- meals out of bed yes/no _____
- other:

(_) Other: _____

Patient/Significant other signature

RN signature

Alteration in Patterns of Urinary Elimination: Incontinence

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Congenital urinary tract anomalies: <hr/> <input type="checkbox"/> Disorders of urinary tract: _____ <hr/> <input type="checkbox"/> Drug therapy <input type="checkbox"/> Environmental barriers to bathroom <input type="checkbox"/> Estrogen deficiency <input type="checkbox"/> Inability to communicate needs	<input type="checkbox"/> Lack of privacy <input type="checkbox"/> Loss of perineal tissue tone <input type="checkbox"/> Neurogenic disorder or injury <input type="checkbox"/> Prostatic enlargement <input type="checkbox"/> Stress/fear <input type="checkbox"/> Other: _____ <hr/> <hr/>
---	---

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Urgency followed by incontinence. <input type="checkbox"/> Other: _____
---	---

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Be continent at all times.

Be continent during waking hours.

Other:

Monitor I & O, including patterns of urinary incontinence.

Instruct to start and stop stream during urination.

Ask physician for pelvic floor exercises. Order and teach as follows:

_____ x _____ (# of times).

Limit fluids 2-3 hours prior to bedtime.

No fluids after: _____

Awaken patient at night to void at: _____ or q _____ hours.

Provide urinal/bedpan/ bedside commode in easy access.

Place call light within reach at all times.

Provide comfort measures (sitz baths: warm perineal soaks as needed).

Other: _____

Patient/Significant other signature

RN signature

Alteration in Patterns of Urinary Elimination: Retention

() Actual () Potential

Related To:

[Check those that apply]

() Anxiety
 () Fecal impaction
 () Flaccid bladder
 () Medications
 () Packing
 () Stones
 () Weak or absent sensory and/or motor impulses
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Bladder distention (not related to acute, reversible etiology). () Distention with small frequent voids or dribbling (overflow incontinence). () 100 ml or more residual of urine.
Minor: <i>(May be present)</i>	() The individual states that it feels as though the bladder is not empty after voiding.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Void in the amount of:

Have urine residual less than 30cc.

Verbalize knowledge of signs and symptoms of infection.

Other:

Palpate bladder for distention q____ hours or after each void.

Monitor I & O.

Attempt to stimulate relaxation of urethral sphincter by:

- running water
- providing warm water for patient to place hand/fingers in
- other:

Provide privacy.

Intermittent straight cath q____ hours per physician order.

Other: _____

Patient/Significant other signature

RN signature

Knowledge Deficit

() Actual () Potential

Related To:

[Check those that apply]

() New diagnosis: _____

() Language differences: _____

() Hospitalization

() Diagnostic test: _____

() Surgical procedure: _____

() Medications: _____

() Pregnancy

() Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Verbalizes a deficiency in knowledge or skill. () Requests information. () Expresses and inaccurate perception of health status. () Does not correctly perform a desired or prescribed health behavior.
Minor: <i>(May be present)</i>	() Lack of integration of treatment plans into daily activities. () Exhibits or expresses psychological alteration, (anxiety, depression) resulting from misinformation or lack of information.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Describe disease process, causes, factors contributing to symptoms.

Describe procedure(s) for disease or symptom control.

Identify needed alterations in lifestyle.

Other:

Assess patient's readiness to learn by assessing emotional response to illness:

- Acceptance
- Anger
- Anxiety
- Denial
- Depression
- Other:

Allow person to work through and express intense emotions prior to teaching.

Examine patient's health beliefs:

Assess patient's desire to learn.

Assess preferred learning mode:

- Auditory
- Group
- One to one
- Visual
- Other:

Assess literacy level.

Provide health teaching and referrals: _____

Plan and share necessity of learning outcomes with patient - s/o.

(_) Evaluate patient - s/o behaviors as evidence that learning outcomes have been achieved:

(_) Other: _____

Patient/Significant other signature

RN signature

Ineffective Airway Clearance

() Actual () Potential

Related To:

[Check those that apply]

() Artificial airway
 () Excessive or thick secretions
 () Inability to cough effectively
 () Infection
 () Obstruction/restriction
 () Pain
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Ineffective cough. () Inability to remove airway secretions.
Minor: <i>(May be present)</i>	() Abnormal breath sounds. () Abnormal respiratory rate, rythm, depth.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

() Maintain patent airway A.E.B.:

- Clear breath sounds or breath sounds consistent with own baseline.
- Respirations easy and unlabored.
- Normal resp. rate.

() Other:

() Assess respiratory rate, depth, rythm, effort, and breath sounds q ___ hours.

() Position: HOB elevated ___ degrees.

() Promote optimum level of activity for best possible lung expansion:

- Ambulate q ___ for ___ min.
- Chair q ___ for ___ min.
- Turn/reposition q ___.

() Suction q ___ hours (and prn) per:

- Nasal
- Oral
- Tracheal

() Encourage fluids when indicated.

() Other: _____

 Patient/Significant other signature

 RN signature

Ineffective Breathing Patterns

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Allergic response <input type="checkbox"/> Anesthesia <input type="checkbox"/> Aspiration <input type="checkbox"/> COPD <input type="checkbox"/> Decreased lung compliance <input type="checkbox"/> Fatigue <input type="checkbox"/> History of smoking	<input type="checkbox"/> Immobility <input type="checkbox"/> Medications (narcotics, sedatives, analgesics) <input type="checkbox"/> Neuromuscular impairment (eg. MS, Guillain-Barre) <input type="checkbox"/> Surgery or trauma <input type="checkbox"/> Pain <input type="checkbox"/> Other: _____ _____ _____
--	--

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Changes in respiratory rate or pattern from baseline. <input type="checkbox"/> Changes in pulse (rate, rhythm).
Minor: <i>(May be present)</i>	<input type="checkbox"/> Orthopnea () Tachypnea () Hyperpnea <input type="checkbox"/> Splinted, guarded respirations.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Demonstrate an effective respiratory rate, depth, and pattern A.E.B.: <ul style="list-style-type: none"> ● Color pink/ absence of cyanosis. ● Absence of diminished breath sounds. <input type="checkbox"/> Other:		<input type="checkbox"/> Assess color, respiratory rate, depth, effort, rhythm and breath sounds q ____ hours. <input type="checkbox"/> Position to facilitate optimum breathing patterns: <ul style="list-style-type: none"> ● HOB elevated ____ degrees. ● Turn q ____ hours. <input type="checkbox"/> Cough and deep breath q ____	

hours.

(_) Increase activity as tolerated to promote maximum diaphragmatic excursion:

(_) Other: _____

Patient/Significant other signature

RN signature

Noncompliance

() Exercise () Follow-up Care () Medication () Other

Related To:

[Check those that apply]

<input type="checkbox"/> Chronic illness <input type="checkbox"/> Fatigue <input type="checkbox"/> Depression <input type="checkbox"/> Non supportive family <input type="checkbox"/> Inadequate/incomplete instructions <input type="checkbox"/> Denial of Dx	<input type="checkbox"/> Side effects of therapy/med <input type="checkbox"/> Impaired ability to perform tasks <input type="checkbox"/> Expensive therapy <input type="checkbox"/> Other: _____ _____ _____
---	---

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Verbalization of non-compliance or non-participation or confusion about thrapy and/or <input type="checkbox"/> Direct observation of behavior indicating non-compliance
Minor: <i>(May be present)</i>	<input type="checkbox"/> Missed appointments () Partially used or unused medications <input type="checkbox"/> Progression of disease process. () Persistence of symptoms

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Demonstrate compliance with: <input type="checkbox"/> Other:		<input type="checkbox"/> Assess patient's: <ul style="list-style-type: none"> ● Understanding of disease process ● Barriers to compliance ● Life-style ● Support system ● Perception of non-compliance ● Other: <input type="checkbox"/> Allow patient and s/o to verbalize feelings about situation/	

(_) Adapt regime to patient's level of comprehension.

(_) Involve patient - s/o in planning compliance.

(_) Emphasize positive aspects of compliance.

(_) Instruct patient - s/o about meds:

- Side effects
- Dosage
- Other:

(_) Set goals with patient.

(_) Consult with:

- PT
- OT
- Home Health
- Social Services

(_) Other: _____

Patient/Significant other signature

RN signature

Potential for Infection

(_) Actual () Potential

Related To:

[Check those that apply]

(_) Alteration in skin integrity: _____
(_) Bone marrow depression.
(_) Indwelling catheter: _____
(_) Nutritional deficiencies: _____
(_) Surgical/invasive procedures: _____
(_) Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	(_) Altered production of leukocytes. (_) Altered immune response.
Minor: <i>(May be present)</i>	(_) Altered circulation. (_) Presence of favorable conditions for infection. (_) History of infection.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Remain infection free A.E.B.:

Demonstrate complete recovery from infection A.E.B.:

Other:

Assess temperature q ____ hrs.

Inspect and record signs of erythema, induration, foul smelling drainage, from or around wound, skin, invasive line, mouth/throat, or other site q ____ hrs.

Asses for cloudiness of urine q ____ hrs.

Report abnormal changes in WBC count and/or pathogenic growth on cultures.

Utilize good handwashing technique.

Visitors and health care workers with active infection are to avoid contact with patient.

Avoid invasive prodecures; i. e. rectal temperatures, bladder catheters, etc.

Encourage high protein/high carbohydrate foods/fluids when indicated.

Explore with patient potential etiological factors which potentiate infection and include appropriate health teaching.

Other: _____

Patient/Significant other signature

RN signature

Powerlessness

(_) Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Inability to communicate:_____
<input type="checkbox"/> Inability to perform ADL:_____
<input type="checkbox"/> Inability to perform role responsibilities:_____
<input type="checkbox"/> Progressive debilitating disease:_____
<input type="checkbox"/> Hospital or institutional limitations:_____
<input type="checkbox"/> Other:_____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Overt or covert expressions of dissatisfaction over inability to control situation. (exg: illness, prognosis, care, recovery rate)
Minor: <i>(May be present)</i>	<input type="checkbox"/> Refuses or is reluctant to participate in decision-making () Apathy () Resignation <input type="checkbox"/> Aggressive/violent/acting out behavior () Anxiety () Uneasiness () Depression

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

The patient will:

Identify factors that can be controlled:

Makes decisions regarding treatment and future when possible.

Other:

Assess causative or contributing factors.

Assess patient's usual response to problems:

- Internal - how individual makes own changes
- External - expects others to control problems or leaves to fate, or luck

Increase communication

- Explain all procedures and..
- Treatments
- Medications
- Results of labs/tests
- Condition
- All changes
- Rules
- Options
- Other:

Allow time to answer questions (15 min. ea shift)

Realistically point out positive changes in person's condition.

Allow patient to make as many decisions as possible.

Provide opportunities for patient and family to participate in care.

Encourage participation from patient who depends on others to make own decisions.

Encourage patient to verbalize feelings and concerns.

Other: _____

Patient/Significant other signature

RN signature

Rape Trauma Syndrome

(_) Actual () Potential

Related To:

[Check those that apply]

<p>Somatic Response:</p> <p>(_) Gastrointestinal irritability (N/V, anorexia)</p> <p>(_) Genitourinary discomfort (pain, pruritus)</p> <p>(_) Skeletal muscle tension (spasm, pain)</p> <p>(_) Other: _____</p> <hr/> <p>Sexual responses:</p> <p>(_) Mistrust of men (if victim is woman)</p> <p>(_) Change in sexual behavior</p> <p>Other: _____</p>	<p>Psychological responses:</p> <p>(_) Denial</p> <p>(_) Emotional shock</p> <p>(_) Anger</p> <p>(_) Fear</p> <p>(_) Guilt</p> <p>(_) Panic on seeing assailant or scene of attack</p> <p>(_) Other: _____</p> <p>_____</p> <p>_____</p>
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As evidenced by:

[Check those that apply]

<p>Major: (Must be present)</p>	<p>(_) Reports or evidence of sexual assault</p>
<p>Minor: (May be present)</p>	<p>If the victim is a child, parent(s) may experience similar responses:</p> <p>Acute Phase:</p> <ul style="list-style-type: none"> ● Somatic responses: Gastro-intestinal irritability (N/V, anorexia) Genitourinary discomfort (pain, pruritus) Skeletal muscle tension (spasm, pain) ● Psychological responses: Denial, emotional shock, anger, fear of being alone or that the rapist will return [a child victim will fear punishment, repercussions, abandonment, rejection] guilt, panic on seeing assailant or scene of attack ● Sexual responses: Mistrust of men (if victim is a woman), change in sexual behavior. <p>Long term phase:</p> <ul style="list-style-type: none"> ● Any response of the acute phase may continue if resolution does not occur. ● Psychological responses: Phobias, nightmares, or sleep disturbances

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	<p>The patient will:</p> <p><input type="checkbox"/> Experience decreased symptoms of:</p> <p><input type="checkbox"/> Discuss assault.</p> <p><input type="checkbox"/> Express feelings concerning the assault and the treatment.</p> <p><input type="checkbox"/> Identify members of support system and utilize them appropriately.</p> <p><input type="checkbox"/> Return to pre-crisis level of functioning.</p> <p><input type="checkbox"/> Other:</p>		<p><input type="checkbox"/> Assess for psychological responses:</p> <ul style="list-style-type: none"> ● Phobias ● Denial ● Anger ● Depression ● Guilt ● Other: <p><input type="checkbox"/> Inspect urine and external genitalia for bleeding.</p> <p><input type="checkbox"/> Observe patient's behavior carefully and record objective data.</p> <p><input type="checkbox"/> Promote trusting relationship.</p> <p><input type="checkbox"/> Provide crisis counseling within one hour of rape trauma event.</p> <p><input type="checkbox"/> Help patient meet personal needs of:</p> <hr/> <p><input type="checkbox"/> Allow patient to express feelings.</p> <p><input type="checkbox"/> Discuss with patient previous coping mechanisms.</p> <p><input type="checkbox"/> Explore with patient her/his strengths and resources.</p> <p><input type="checkbox"/> Offer feedback to patient on</p>	

feelings verbalized.

Explore sexual concerns with patient.

Initiate health teaching and referrals as necessary.

Other: _____

Patient/Significant other signature

RN signature

Self Care Deficit: Bathing

() Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Neuromuscular impairment <input type="checkbox"/> Visual disorders <input type="checkbox"/> Trauma or surgical procedure <input type="checkbox"/> External devices <input type="checkbox"/> Aging process	<input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Immobility <input type="checkbox"/> Nonfunctioning or missing limbs <input type="checkbox"/> Other: _____ _____ _____
--	--

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Unable or unwilling to wash body or body parts. <input type="checkbox"/> Unable to obtain water. <input type="checkbox"/> Unable to regulate temperature or water flow.
---	--

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Perform bathing activity at expected optimal level. <input type="checkbox"/> Demonstrate use of adaptive devices for bathing. <input type="checkbox"/> Other:		<input type="checkbox"/> Assess for causative factors. <input type="checkbox"/> Provide opportunities to relearn or adapt to activity. <input type="checkbox"/> Teach patient to use affected extremity to accomplish tasks. <input type="checkbox"/> Consistent bathing routing at _____ am/pm every day. <input type="checkbox"/> Provide as much privacy as possible by pulling curtains and closing doors.	

Provide equipment within easy reach.

Encourage independence.

Reinforce success for task accomplished.

OT consult for:

- Adaptive devices
- Safety measures for home
- Other:

Other: _____

Patient/Significant other signature

RN signature

Self Care Deficit: Dressing and Grooming

() Actual () Potential

Related To:

[Check those that apply]

() Neuromuscular impairment: _____

() Impaired visual acuity

() Immobility

() Weakness

() Decreased level of consciousness

() Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	<input type="checkbox"/> Impaired ability to put on or take off clothing. <input type="checkbox"/> Unable to obtain or replace article of clothing. <input type="checkbox"/> Unable to fasten clothing. <input type="checkbox"/> Unable to groom self satisfactorily
---	---

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Demonstrate increased ability to dress/groom self. <input type="checkbox"/> Demonstrate ability to cope with the necessity of having someone else assist him/her in performing the task. <input type="checkbox"/> Demonstrate ability to learn how to use adaptive devices to		<input type="checkbox"/> Allow sufficient time for dressing and undressing, since the task may be tiring, painful, and difficult. <input type="checkbox"/> Promote independence in dressing through continual and unaided practice. <input type="checkbox"/> Choose clothing that is loose fitting, with wide sleeves and pant legs, and front fasteners.	

facilitate optimal independence in the task of dressing/grooming.

Other:

Lay clothes out in the order in which they will be needed to dress.

Avoid placing clothing to blind side if patient has field cut, until patient is visually accommodated to surroundings; encourage patient to turn head to scan entire visual field.

Consult/refer to PT/OT for teaching application of prosthetics.

Provide dressing aids as necessary (dressing stick, swedish reacher, zipper pull, button-hook, long handled shoehorn, shoe fasteners adapted with elastic laces, velcro closures, flip back tongues).

Plan for person to learn and demonstrate one part of an activity before progressing further.

Make consistent dressing/grooming routine to provide a structured program to decrease confusion.

Other: _____

Patient/Significant other signature

RN signature

Sleep Pattern Disturbance

(_) Actual () Potential

Related To:

[Check those that apply]

<input type="checkbox"/> Impaired oxygen transport	<input type="checkbox"/> Lack of exercise
<input type="checkbox"/> Impaired elimination	<input type="checkbox"/> Anxiety response
<input type="checkbox"/> Impaired metabolism	<input type="checkbox"/> Life-style disruptions
<input type="checkbox"/> Immobility	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Medication	_____
<input type="checkbox"/> Hospitalization	_____

As evidenced by:

[Check those that apply]

Major: (Must be present)	<input type="checkbox"/> Difficulty falling or remaining asleep
Minor: (May be present)	<input type="checkbox"/> Fatigue on awakening or during the day <input type="checkbox"/> Dozing during the day <input type="checkbox"/> Agitation <input type="checkbox"/> Mood alterations

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: <input type="checkbox"/> Demonstrate an optimal balance of rest and activity A.E. B. ____ hours of uninterrupted sleep at night. <input type="checkbox"/> Remain awake during the day. <input type="checkbox"/> Other:		<input type="checkbox"/> Explore with patient potential contributing factors. <input type="checkbox"/> Maintain bedtime routine per patient preference. <ul style="list-style-type: none"> ● Likes to go to bed @ ____ pm. ● Prefers quiet ● Darkness ● Night light ● Music <input type="checkbox"/> Takes sleeping pill as ordered	

by a physician @ ____ pm.

(_) Provide comfort measures to induce sleep:

- Back rub
- Herbal tea-warm milk
- Pillows for support
- Bedtime snack when appropriate.
- Pain medication if needed.
- Other:

(_) Limit nighttime fluids to:

(_) Void before retiring.

(_) Coordinate treatment/meds to limit interruptions during sleep period.

(_) Limit the amount and length of daytime sleeping:

(_) Increase daytime activity:

(_) Other: _____

Patient/Significant other signature

RN signature

Social Isolation

() Actual () Potential

Related To:

[Check those that apply]

() Death of s/o
 () Divorce
 () Substance abuse
 () Illness: _____

 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Expressed feelings of unexplained dread or abandonment () Desire for more contact with people
Minor: <i>(May be present)</i>	() Time passing slowly () Inability to concentrate and make decisions () Feelings of uselessness () Doubts about ability to survive

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: () Identify the reasons for his/her feelings of isolation. () Identify ways of increasing meaningful relationships. () Identify appropriate diversional activities. () Other:		() Encourage patient to verbalize feelings. () Assist to identify causative and contributing factors. () Assist to reduce or eliminate causative and contributing factors: _____ _____ _____	

(_) Assist to identify diversional activities. (See Diversional Activity Deficit)

(_) Initiate referrals as needed or increase social relationships:

(_) Other: _____

Patient/Significant other signature

RN signature

Spiritual Distress

() Actual () Potential

Related To:

[Check those that apply]

() Pain
 () Trauma
 () Loss of body part/function
 () Terminal illness
 () Death of s/o
 () Unable to practice religious rituals
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() Experiences a disturbance in belief system.
Minor: <i>(May be present)</i>	() Questions credibility of belief system. () Demonstrates discouragement or despair. () Is unable to practice usual religious rituals. () Has ambivalent feelings (doubts) about beliefs. () Expresses that he/she has no reason for living. () Feels a sense of spiritual emptiness. () Shows emotional detachment from self and others. () Expresses concern, anger, resentment, fear - over the meaning of life, suffering, death. () Requests spiritual assistance for a disturbance in belief system.

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:

	<p>The patient will:</p> <p><input type="checkbox"/> Continue spiritual practices not detrimental to health.</p> <p><input type="checkbox"/> Express decreasing feelings of guilt and anxiety.</p> <p><input type="checkbox"/> Express satisfaction with spiritual condition.</p> <p><input type="checkbox"/> Other:</p>		<p><input type="checkbox"/> Assess current level of spiritual state: Comfort, distress, desire for minister, priest, rabbi to visit, desire to practice religious rituals.</p> <p><input type="checkbox"/> Implement patient requests regarding spiritual needs.</p> <p><input type="checkbox"/> Contact spiritual/religious advisor of patients choice.</p> <p><input type="checkbox"/> Discuss impact of stress on challenging one's spiritual beliefs.</p> <p><input type="checkbox"/> As patient desires, allow opportunity to discuss belief system, the meaning of illness/suffering within this system.</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
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Patient/Significant other signature

RN signature

Violence

() Actual () Potential

Related To:

[Check those that apply]

() Acute agitation
 () Poor impulse coordination
 () Mania
 () Feelings of helplessness
 () Other: _____

As evidenced by:

[Check those that apply]

Major: <i>(Must be present)</i>	() History of harm to others () Destruction of property () Overt aggressive acts
Minor: <i>(May be present)</i>	() Acute agitation () Suspiciousness () Persecutory delusions () Inflexible () Verbal threats of physical assault () Low frustration tolerance () Poor impulse control () Feelings of helplessness () Excessively controlled

Date & Sign.	Plan and Outcome <i>[Check those that apply]</i>	Target Date:	Nursing Interventions <i>[Check those that apply]</i>	Date Achieved:
	The patient will: () Experience control of behavior with assistance from others. () Describe causation and possible preventative measures. () Other:		() Assess patient's potential for violence and past history. () Maintain patient's personal space, (i.e. allow 5 times greater space than that for individual in control). () Seclusion: Check q _____ () Restraints: _____ Check q ____	

Set limits:

Decrease noise level.

Provide environment that provides safety and reduces agitation:

Acknowledge feelings.

Explore the precipitating event.

Other: _____

Patient/Significant other signature

RN signature

(_)Actual () Potential

Related To:

As evidenced by:

Major: <i>(Must be present)</i>	
Minor: <i>(May be present)</i>	

Date & Sign.	Plan and Outcome	Target Date:	Nursing Interventions	Date Achieved:

	The patient will:			
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Patient/Significant other signature

RN signature

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