Enter details or affix label here:-
Full Name.....
Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Patient has dysphagia | **Patient Goal**: To remain hydrated and prevent aspiration |
| | **Nursing Action** | |
| | Administer fluids as prescribed and according to hospital policy | |
| | Record accurate fluid balance charts | |
| | Provide mouth care 4 hourly or PRN | |
| | Refer to Speech & Language Therapist for swallow assessment and appropriate diet | |
| | Explain rationale to patient and family | |
| | Ensure recommendations as per SLT are displayed | |

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Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Patient has Cellulitis<br>**Patient Goal**: Patient's cellulitis will be resolved<br>Prevent complications | |
| | **Nursing Action** | |
| | Obtain 4 hourly observations or more frequently if necessary | |
| | Administer antibiotics/medications as prescribed | |
| | Observe effects or side effects of same | |
| | Monitor improvement or deterioration in patient's condition and report and document same | |
| | Observe site of infection for improvement or deterioration | |

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Unit No:.....
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# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Chest Infection | **Patient Goal**: Eradicate infection; Alleviate symptoms | |
| | **Nursing Action** | |
| | Monitor observations four hourly or as condition dictates | |
| | | |
| | Administer oxygen therapy as prescribed | |
| | Observe effects and / or side effects | |
| | | |
| | Administer medications as prescribed | |
| | Observe effects and / or side effects | |
| | | |
| | Refer patint to physio and respiratory nurse as appropriate | |
| | | |
| | Nurse patient beside oxygen and suction points | |
| | | |
| | Send blood / sputum samples to lab as requested by MO | |
| | | |
| | Ensure patient aware of treatment | |
| | Offer reassurance as required | |
| | | |
| | Inform MO of any change in condition, | |
| | Report and record progrss | |

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Full Name: .....
Unit No: .....
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# NURSING CARE PLAN

| DATE/TIME | | | | SIGNATURE |
|---|---|---|---|---|
| | Patient Problem | | Patient Goal | |
| | Patient has a deep venous thrombosis | | Patient's pain will be alleviated | |
| | | | | |
| | | | | |
| | | | | |
| | Nursing Action | | | |
| | Ensure patient maintains bed rest. | | | |
| | Administer heparin therapy as prescribed. | | | |
| | Obtain daily calf measurements and record same. as directed by MO | | | |
| | Prepare patient for venogram and provide full explaination of same. | | | |
| | Administer analgesia as prescribed and record and report effects or any side effects of same. | | | |
| | Obtain bloods for INR as requested by MO. | | | |
| | Administer warfarin therapy ~~as~~ if prescribed. As per MO. | | | |
| | Observe for any signs of haemorrhage and report and record same. | | | |
| | Provide warfarin booklet and refer to warfarin clinic or district nurse on discharge. if applicable. | | | |

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Full Name.....
Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|

| Patient Problem | Patient Goal |
|---|---|
| Death and dying | Patient identifies source of fear |
| End of life issues | related to dying |
| | Patient implements a positive |
| | coping mechanism and |
| | verbalises reduction of fear |

| Nursing Action |
|---|
| Help patient express his or her fears by careful and thoughtful questioning |
| Assess the nature of the patients fear and methods he or she uses to cope with that fear |
| Document verbal and non verbal expression of fear |
| Spend time with the patient |
| While interacting with the patient, maintain a calm and accepting manner that expresses care and concern |
| Confirm that fear is a normal and appropriate response to situations when pain, danger or loss of control is anticipated or experienced |
| Assist patient in identifying, coping and comfort strategies that were helpful before |
| Encourage rest and relaxations |
| Instruct patient in the performance of self calming measures<br>- Breathing exercises<br>- Relaxation, meditation, or guided imaginary exercises |

Enter details or affix label here:-
Full Name.....
Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Patient has dysphagia | **Patient Goal**: To remain hydrated and prevent aspiration |
| | **Nursing Action** | |
| | Administer fluids as prescribed and according to hospital policy | |
| | Record accurate fluid balance charts | |
| | Provide mouth care 4 hourly or PRN | |
| | Refer to Speech & Language Therapist for swallow assessment and appropriate diet | |
| | Explain rationale to patient and family | |
| | Ensure recommendations as per SLT are displayed | |

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Full Name: .....
Unit No: .....
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# NURSING CARE PLAN

| DATE/TIME | | | SIGNATURE |
|---|---|---|---|
| | Patient Problem | Patient Goal | |
| | Patient has dysarthria | To be able to communicate | |
| | Nursing Action | | |
| | Refer to Speech Therapist. | | |
| | Provide reassurance to patient and family. | | |
| | Provide and use communication aids as necessary | | |
| | Speak slowly and clearly to attempt to ensure understanding. | | |
| | Monitor progress. | | |

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Full Name.....
Unit No:.....
Ward.....

# NURSING CARE PLAN

DATE/TIME | SIGNATURE

| Patient Problem | Patient Goal |
|---|---|
| Low Hb | Maintain Hb within |
| Requires blood | normal limits. |
| transfusion | Patient will receive |
| | blood without |
| | adverse effect. |

Nursing Action

-Educate patient and family re the reason for blood transfusion and procedure for administering the blood products.
-Allow opportunity to express anxieties.
-Provide factual information.
-Obtain patient consent for blood product
-Obtain venous access.
-Administer blood product as per hospital policy and protocol.
-Monitor clinical observations as per Policy.
-Monitor for any signs or symptoms of adverse reaction. Treat urgently should complications occur as per policy.
-Complete relevant documentation according to hospital policy.
-Monitor Hb levels as per MO.
-Report and record.

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Full Name.....
Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Patient has high blood pressure | **Patient Goal**: Blood pressure will be reduced to normal limits |
| | **Nursing Action** | |
| | Monitor BP 4 hourly or more frequently if required | |
| | Administer medication as prescribed | |
| | Observe and record effects and any side effects of same | |
| | Reassure patient to avoid anxiety | |
| | Report and record any abnormalities to MO | |

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# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | Patient Problem / Patient Goal | |
| | Patient has nausea and vomiting / Patient's nausea and vomiting will be relieved | |
| | | |
| | | |
| | | |
| | Nursing Action | |
| | | |
| | Record accurate fluid balance chart. | |
| | | |
| | Record vital signs 4 hourly or more frequent if required. | |
| | | |
| | Administer anti-emetic as prescribed by MO. | |
| | | |
| | Observe, record and report effects or any side effects of same. | |
| | | |
| | Ensure buzzer and emesis bowl is at hand. | |
| | | |
| | Observe vomit for colour, consistency and volume. | |
| | | |
| | Reassure patient and record progress in notes. | |
| | | |
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Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Patient has NG Tube | **Patient Goal**: To maintain patency |
| | **Nursing Action** | |
| | Insert NG tube as per hospital policy | |
| | Check aspirate using ph indicator strips and ensure ph is between 0 - 5.5 prior to using NG | |
| | Contact dietician to commence patient on NG regime | |
| | Flush NG tube with water before and after administering medications NG feed | |
| | If NG tube blocks order Pancrex v/Sodium bicarbonate to unblock NG tube | |
| | Communicate procedure to patient / offer reassurance | |
| | Allow patient to express any anxieties | |
| | Take bloods if requested by doctor/dietician | |
| | Ensure patient has x ray to check position of NG | |
| | Provide mouth care four hourly or PRN | |

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Full Name.....
Unit No:.....
Ward

# NURSING CARE PLAN

DATE/TIME SIGNATURE

| Patient Problem | Patient Goal |
|---|---|
| Patient is restless/agitated | Reduce restlessness and promote comfort |

Nursing Action

Provide reassurance and explain all procedures to the patient

Ensure pain relief provided where necessary and is effective for patient

Involve patient's relatives, next of kin or friends where appropriate to reassure and help settle the patient

Contact MO if necessary to see patient if restless/agitation is not relieved

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Unit No:.....
Ward.....

# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Patient suffers from seizures | **Patient Goal**: To maintain safety and treat condition |
| | **Nursing Action** | |
| | Establish cause of seizure activity | |
| | If seizure occurs maintain safety<br>- cot sides<br>- recovery position<br>- oxygen<br>- suction | |
| | Observe patient for duration and severity of seizure | |
| | Note any incontinence or tongue biting | |
| | Obtain half hourly CNS observations following seizure and observe coma scale | |
| | Record accurate seizure chart and obtain 4 hourly observations once patient is fully conscious | |
| | Administer anti-epileptic drugs as prescribed and observe for any side effects of same | |
| | Provide reassurance as necessary | |
| | Record and document progress | |

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# NURSING CARE PLAN

| DATE/TIME | | SIGNATURE |
|---|---|---|
| | **Patient Problem**: Increasing shortness of breath | **Patient Goal**: To alleviate shortness of breath; Establish cause | |
| | **Nursing Action** | |
| | Nurse patient in upright position to aid breathing | |
| | Monitor Spo2, if less than 90% administer oxygen as prescribed | |
| | Monitor Spo2 four hourly until stable | |
| | Assist with investigations as per MO | |
| | Refer to respiratory nurse if appropriate for chest physio | |
| | Allow patient to express fears/anxieties | |