

# **The Nursing Student's Practical Guide to Writing Care Plans**

**By Luanne Begin**

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## PREFACE

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Congratulations for choosing nursing as your career! The nursing program here at Bristol Community College will provide you with the academic knowledge and clinical skills you need to pass the NCLEX, obtain your license, and begin working as a registered nurse. You will face many challenges over the next two years which will require you to work diligently and conscientiously in order to meet the program objectives and achieve your goals. You will be expected to consistently strive for, reach, and then exceed your personal best as you prepare to enter the profession of nursing. Trust me when I tell you that it can be done!

As a recent graduate of the nursing program I understand, from a student's point of view, the unique struggles you are facing. I can remember being exactly where you are . . . intimidated and overwhelmed by the daunting task of writing the perfect care plan; or, if not perfect, at least good enough to earn that coveted and all-important "satisfactory" from my clinical instructor. I often wished I had an example, or model, that I could follow which would assist me in navigating my way through the writing requirements of this curriculum. My fellow students and I often remarked on how much easier it would be to write a care plan if only we had one in front of us to look at! As a long-time tutor at Bristol Community College, I have always been passionate about helping other students, and so as the end of nursing school approached, I decided to create this manual in the hope that it would give incoming students the kind of model my classmates and I always wished we'd had.

This manual has been designed to assist you in meeting the writing requirements of the nursing program. It is important to understand that the clinical component of this curriculum is not limited to simply mastering technical skills and providing direct patient care; it requires you to critically think, and then write about, all aspects of that care. Before you ever meet your patient, you will be asked to conduct research, collect data, and present, in writing, a comprehensive plan detailing your understanding of that patient, including his or her medical, physical, emotional, and psychosocial needs, and how you plan to meet those needs.

At the end of each week, you will reflect on your experience in the clinical area and then write a self-evaluation documenting your thoughts and feelings about your performance. As a tutor, I understand that many students are intimidated by, or simply uneasy about, the prospect of writing. Worse, I've met quite a few who claim to hate it! If you believe yourself to be in one of these categories, then this manual is for you. It has been designed to eliminate any reservations you may have about your ability to write successfully, and with confidence, by showing you exactly what you can expect regarding care plans and self-evaluations. I hope you will find this a practical and valuable learning tool as you strive for excellence in the clinical area.

As you make your way through nursing school, struggling and sacrificing, please take the time to remind yourself, often, that you have been selected for one of the finest nursing education programs in this region and that you can, and will, meet each challenge successfully, and be rewarded beyond measure for your efforts.

Luanne Begin  
Student Nurse, Class of 2007  
Bristol Community College

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## Section One: The Nursing Process

Potter & Perry (2005) describes the nursing process as “a system to organize and deliver nursing care” (p.279). As you may already know, the nursing process consists of five steps: assessment, diagnosis, planning, implementation, and evaluation. While you have studied each of these aspects of the nursing process in depth during your core curriculum, I thought it might be helpful to provide a brief overview of how each of these steps applies to care planning.

Assessment is the deliberate and systematic collection of data (Potter & Perry, 2005). This is the very first step in writing a care plan. Indeed, it would be almost impossible to create a map of care for a patient about whom you have no information. On the evening before clinical, you will write your care plan based entirely on information you have gathered from the patient's written records. Although you have not yet seen, touched, smelled, or listened to your patient, this research of the patient's chart is assessment. It allows you to understand the patient's history, reason for admission to the hospital, current medications, laboratory values, and current health status. You cannot proceed to the next step in care planning without it. Please take my advice and conduct a thorough examination of your patient's medical record; you do not want to be at home writing a care plan only to realize that you are missing a critical piece of information.

Nursing diagnoses are clinical judgments about actual or potential problems a patient may be facing. Based on your assessment, you will identify the nursing diagnoses most appropriate for your patient. The North American Nursing Diagnoses Association (NANDA) is the organization that defines and classifies nursing diagnoses. It is required that all diagnoses included in your care plan be NANDA approved. This is important because NANDA provides a common language that all nurses use and understand. You have purchased a required text that provides you with a comprehensive list of NANDA-approved

diagnoses. Early on in your career as a nursing student, you are expected to use only that text as a resource. Later, you may be allowed to use several different texts on nursing diagnoses and/or care planning, depending on your instructor's preferences, as long as all your diagnoses remain NANDA-approved. If your instructor does not object, you will definitely want to invest in two or three nursing diagnoses/care planning books.

In your first year you will begin by identifying one diagnosis, then progress to identifying three, and then five. In your second year you will identify fifteen. You will always begin with the nursing diagnosis with the highest priority for the patient, and proceed to list the rest in order of decreasing priority. To do this, use the Basic Human Needs list (appendix A). Generally, an *actual* diagnosis takes priority over a *risk for* diagnosis. For example, Impaired Skin Integrity (an actual problem) would be a higher priority than Risk for Infection (a potential problem). However, there can be exceptions, and most of these, thankfully, can be discerned with common sense. Risk for Injury would naturally take precedence over Activity Intolerance.

The writing process is important when it comes to diagnosis. You may find it helpful to first think about and then write down on a piece of scrap paper, without regard to what is most important, any and all problems you believe the patient may have based on your assessment. From there, you can critically think about and begin to rank your diagnoses according to priority, before committing to actually writing them in your care plan.

## **Planning**

The planning phase of the nursing process is when you will decide which care measures are appropriate for your patient. Each nursing diagnosis listed in your text will have a corresponding list of interventions and rationales. Planning care involves carefully reading through each listed intervention and asking yourself if that intervention can or should be carried out with your patient. For example, an intervention listed under Impaired Gas Exchange reads as follows: "If the patient is obese or has ascites, consider positioning in reverse Trendelenberg's position at 45 degrees for short periods as tolerated" (Ackley & Ladwig, 2006, p.439). Now, if your patient is not obese and does not have ascites, this intervention is not indicated and should not be included in your plan of care. To reiterate, include only those care measures which are relevant to your patient.

It is very important that you learn, early on, how to make your interventions specific to your patient. Trust me when I tell you that you will likely save

yourself a lot of time, and possibly avoid having your care plan returned to you for revisions, if you are conscientious about doing this. As an illustration, suppose you have a diagnosis of Acute Pain and one of the listed interventions is “administer analgesics, as needed.” What you will need to do is look at your patient’s available medications for pain relief and write the intervention as follows: “administer Dilaudid, 2 mg, IV q 4 hours @ 0800 and 1200.” Notice that the medication, dose, route, and schedule is listed and that the times are specific to the shift when you will be caring for the patient. Also, be cognizant of the use of pronouns in your interventions. Use *he* or *she* where appropriate. This lets your instructor know that you are tailoring your care to your patient. You will see more examples of specificity as you look at the sample care plans in this manual.

Each of the interventions you plan has a corresponding rationale; a scientific explanation for why that nursing care measure is appropriate. Beginning in your second semester you will be required to list a rationale for each of your interventions. Many students find this to be a tedious and somewhat superfluous step. I urge you to examine each rationale carefully, as it is an important component of your learning. As nurses, it is essential that we understand not only *how* we do things, but *why* we do things. Rationales reflect what research has proven to be best-practice.

## **Implementation**

Implementation is simply carrying out the interventions you have identified as being necessary for your patient’s care. Potter and Perry (2005) teaches that “preparation for implementation ensures efficient, safe, and effective nursing care” (p.344). Part of your preparation involves having a thorough care plan completed before you arrive for clinical. This is mandatory, and for good reason. How else would you know what to do with, and for, your patient? When you report for clinical, you must assess/reassess your patient in order to determine whether your planned nursing interventions are still appropriate or necessary for the patient. Implementation involves many steps including, but not limited to, direct care, counseling, teaching, and prevention of complications. A well-thought out and comprehensive care plan guides you through these steps and helps you practice efficiently, safely, and effectively.

## **Evaluation**

The final step in the nursing process, evaluation, allows us to determine whether our use of the nursing process was effective. It asks the question, “Did



the patient (or the patient's condition/well-being) improve"? Each nursing diagnosis you identify has specific and measurable desired outcomes. Evaluation is based on whether the expected outcomes were achieved, and not on whether specific interventions were carried out or helpful. This is an important distinction and one you need to understand. For example, a diagnosis of Impaired Physical Mobility suggests the following outcomes:

Patient will (give specific time frame):

- Increase physical activity
- Verbalize feelings of increased strength and ability to move
- Demonstrate use of adaptive equipment (specify crutches, walker, etc.) to increase mobility

Now, while some of your interventions for this diagnosis will include treating the patient's pain before activity, using a gait belt while ambulating the patient, and increasing independence of ADL's, evaluation is *not* based on whether these care measures were carried out successfully. Rather, you will be evaluating whether the nursing process was effective as a whole. You will document, on your care plan, whether you believe your assessments, diagnoses, planning, and implementation measures were correct and accurate, and you will need to provide rationales to support your position. Remember that your judgments must be based on whether your patient met, or is progressing towards, the expected outcomes.

Your written evaluation is added to your care plan after you have completed your first day of clinical. Based on your assessments and evaluations, you may need to change your priorities for day two; some of your diagnoses may still be pertinent while others may need to be changed. Pay attention to this part: please resist the temptation to leave your top five priorities unchanged simply because you can get away with it! I have known some students who, because they did not want to have to "work up" another nursing diagnosis, would keep their top five in spite of the fact that changing some of them would have been more appropriate. I understand that adding more work to your care plan after having little sleep and a long day at clinical is the last thing you want to do. However, trust me when I say that doing just that contributes to your clinical education and mastery of the nursing process. If you fail to be conscientious in this area you are cheating yourself and your patients.

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## Section Two: Writing a Care Plan

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Hopefully, you now have a basic understanding of how and why we use the nursing process in order to plan care for our patients. Now I'd like to turn your attention to the methodical steps we take in the actual writing of a care plan. Everyone has a unique writing process; from generating ideas, organizing your information, and writing the body of your work to revising and editing, the writing process can vary between individuals. I encourage you to use the process that works best for you. However, for the purposes of this manual, I will outline the process that I found, through trial and error, to be the most thorough and efficient for me. Bear in mind that this is only a model, and not a concrete or mandatory way to accomplish your goal.

## Getting Started

You have arrived at your clinical site to pick up your assignment, dressed professionally and wearing your crisp, white lab coat, looking very much like the health care provider you are destined to become. If you are a first-year student, you are probably feeling a bit apprehensive, because you are unfamiliar with the unit to which you have been assigned, and you are hesitant about entering the strange and forbidden oasis known as the nurse's station and simply plucking your patient's chart from its designated spot or, worse, right from under the nose of the secretary. (Don't ever do that, by the way. The secretary is a keeper of important information and can be your best friend or worst enemy. Always ask her permission before removing a chart from her domain.) Take a deep breath and relax. Go ahead and remove the chart you need, just be sure to leave a note in its space indicating that a student has the chart and where you will be on the unit. This is extremely important, in case someone from the medical team should need it for any reason.

You are now ready to find a quiet spot and begin researching your patient's medical record in order to obtain the information you need to write your care plan. Have a notebook ready, and start writing.

## **Data Collection and Organization**

First, let me warn you that writing your care plan may take you eight, ten, or even twelve hours. Please don't be alarmed, as this is completely normal. Because writing your care plan can be so time-consuming, it helps to organize your data in such a way that makes it easy to find and refer to once you get home and begin. I found that I saved myself a lot of time by organizing information in a linear fashion that paralleled the format of the care plan. Here, I'll share with you my method, though again, bear in mind that you are not obligated to follow my example.

### **Basic Information**

Begin by writing down the following: your patient's initials, age, date of admission, date of surgery (if applicable), admitting diagnosis, code status, and any allergies. This information will be included on the first page of your care plan.

Know your patient's full name, but do not ever write it in your notes or on your care plan. Remember that all information is confidential and that you are taking quite a bit of it out of the hospital and into your home. If your notes should somehow be misplaced, lost, stolen, or left lying someplace where others might read them and the patient's name is on any page, their private, privileged information would be compromised and you would be in violation of the Health Information Portability and Accountability Act (HIPAA). Please take every conceivable measure to protect your patient's identity.

### **Significant Past History (including social history)**

Note any health issues or medical diagnoses that your patient has (such as diabetes, hypertension, coronary artery disease, emphysema, etc.) other than that which brought them to the hospital. List any previous surgeries. Take down their social history such as who they live with, in what type of home, whether they have family or other sources of support and care, if there is an advanced directive in place and, if so, what type, any cultural or religious considerations, and whether they smoke or use alcohol or illegal drugs.

### **Reason for Present Admission**

Why is the patient in the hospital, how did she come to be there, and what was her condition upon arrival? Your notes here should focus on the details surrounding their current hospital stay.

### **Significant Events Since Admission**

Here is where you will make note of any significant or new findings since the patient came to the hospital. Be sure to look up any diagnostics such as x-rays, ultrasounds, CT scans, MRI's, or EKG's and include their findings. Any complications that have developed, additional surgeries, or new treatments should also be noted.

### **Laboratory Values**

Make a list of all abnormal lab values. Those within normal range should not be included.

### **Medications**

Make a list of all the patients medications. Although there is usually a medication list in the chart, it is better to work from the patient's medication administration sheet. It lets you know which meds have been discontinued or added, and is more current than the list in the chart. It may be helpful to make two medication lists: one for scheduled meds and another for PRN's. These "med sheets" are kept in different locations at different facilities. You will learn their location on your first visit to your assigned unit. As with the chart, always leave a note that you have the med sheets and where you will be on the unit.

### **Kardex**

The Kardexes are located at the nurse's station, usually near the secretary. This is where you will find information about the patient's diet, permitted activity, IV fluids, whether he has a catheter in place, if he is on oxygen, types of dressings and scheduled changes, and any tests he may be scheduled for.

### **Conducting Research**

Once you have all the necessary information, it's time to go home and begin doing research. Again, your preferred writing process should be applied. You

may choose to do all your research before you begin writing, or you may do it as you write. Either way, clear some space around you and prepare to have several books available at arm's reach.

### **Researching Your Patient's Condition**

You need to have at least a basic understanding of any medical condition or surgery affecting your patient. In your first semester of nursing you are required to write out, verbatim, the definitions of these medical conditions and surgeries, citing your sources. In later semesters, you will likely possess a knowledge base about most of the health care issues you will be dealing with in clinical. However, when you don't know, be sure to look the issue up and understand it before you write your care plan and report to clinical. Sources for this information include your Fundamentals and Medical-Surgical textbooks, and *Mosby's Medical Dictionary*.

### **Researching Nursing Diagnoses**

Your *Nursing Diagnosis Handbook*, by Betty Ackley and Gail Ladwig is the primary source for nursing diagnoses. First, critically think and try to identify what your patient's diagnoses might be. Then, open up Ackley, where you will find an alphabetical list of medical conditions and surgeries, and common nursing diagnoses for each. As you consider a diagnosis for your patient, find it in Ackley and read its defining characteristics and related factors. Simply doing that should let you know if the diagnosis is appropriate for your patient.

Once you have completed your list you will "work up" your top diagnoses. This includes writing out all assessments, interventions, and rationales. In your first year, you are required to cite your source for the diagnosis and all rationales. As mentioned previously, take the time to read through each intervention, choose only those that are appropriate for, and make them specific to, your patient.

### **Researching Labs and Diagnostic Tests**

As of this writing, the resource for this information is *A Manual of Laboratory and Diagnostic Tests* by Frances Fischbach. You will utilize this book to evaluate laboratory values such as red blood cell count, hemoglobin, hematocrit, white blood cell count, urinalysis, electrolytes, etc. It provides indications as to why a particular lab value may be high or low. In addition, it outlines procedures for collecting specimens. Diagnostic tests are also explained, with instructions for preparing the patient for testing and how to care for them afterwards. Many

times, when you read a diagnostic report in the patient's chart, it will provide an interpretation of the findings. If by rare chance this is not the case, you may be able to discern an explanation in the textbook. However, if you are not sure what the findings of a diagnostic test may mean, don't try to guess. Bring your question to your clinical instructor, who will assist you in determining the significance of any findings.

### **Researching Medications**

You will research medications in *Springhouse's Nurse's Drug Guide*. For each medication on your list you will need to provide its generic and trade name, dose, route, schedule, times due, pharmacological class, therapeutic class, mode of action (chemical effect), and safe dose. In addition, you must provide the reason the patient is taking the medication, potential side effects and interactions, and all nursing responsibilities related to administering that medication.

If you prepare your care plans on the computer, I strongly recommend that you keep a database of every medication that you research and write up. You will likely administer several medications repeatedly throughout your two years in nursing school. You will save yourself an incredible amount of time if you copy and paste these meds; you will then only need to change the dose, route, schedule, times due and reason the patient is taking the med, as necessary. Be advised, though, that clinical instructors frown on this practice. Their concern is that you are not thoroughly prepared to give the medication and may be cheating yourself out of valuable learning by skipping the repetition of looking up and writing out the med each time you have to give it. This, of course, is a completely valid argument. However, as busy nursing students your time is valuable and you need to use it as effectively as possible. Keeping a database of meds is one way to accomplish that. Just don't do it at the expense of your patients. Be diligent and conscientious and know everything you need to know to safely administer that medication. Your patients' well-being, indeed their lives, depends on your doing that. Also, when copying and pasting, bear in mind that your instructor may quiz you about that drug, and if she does, you'd better have the answers to her questions. If you don't, you may earn yourself a clinical warning.

### **Writing Up Diagnoses, Interventions, and Rationales**

Beginning in your second semester your care plan will have three columns for this. In the first column you will write your diagnosis in two or three parts, depending on your instructor's preference. For example, a two part diagnosis

would read as follows: Imbalanced Nutrition, less than body requirements r/t loss of appetite. This states the diagnosis and the factor it is related to. A three part diagnosis does the same, with the addition of stating the defining characteristics. A three part diagnosis, then, would read like this: Imbalanced Nutrition, less than body requirements r/t loss of appetite m/b recent 30 pound weight loss. Your nursing diagnosis book provides a list of related factors and defining characteristics for each diagnosis. Under your diagnosis you will provide a list of subjective and objective data to support it.

The middle column is for listing your interventions. You will be required to break them down into three sections, which will differ in your first and second year. This may seem a bit confusing, but will be explained and become clear when you look at the sample care plans provided in this manual.

The third column is for listing the rationale for each intervention. Each intervention and corresponding rationale should be numbered and line up next to one another in each column. This organizes your care plan, makes it neat and presentable, and saves your instructor from eye strain.

## **Evaluating Your Priorities (NUR 51 & 52)**

After the first day of caring for your patient you will be required to write an evaluation of the achievement of your priorities. Your priorities for day one are your top nursing diagnoses (three in your first year, five in your second). Evaluating your achievement requires you think about whether that diagnosis was accurate, why you believe it was or was not, and what your plans are regarding that diagnosis for day two. Should you come to realize that one of your top diagnoses is no longer appropriate, you will need to move others up the list or replace it with a new diagnosis. You will, of course, have to write up the interventions and rationales for any additions or changes to the top priorities.

## **Revisions**

You may make revisions to your care plan at any time before giving it to your instructor. Be prepared, though, to hand it over at the end of your second clinical day. Hopefully, it is organized, thorough, detailed, and accurate and comes back to you with the word "Satisfactory" written across the top. If it doesn't, don't be discouraged. Most instructors will allow you to make revisions where they have indicated, and if you do that and turn it back in they will accept it and change it to satisfactory. Sometimes, even after revisions, a care plan just can't be salvaged and your instructor will not accept any more changes. At that point, you will simply have to put that care plan behind you and put your best efforts into the next one.

As with any new challenge, when you first begin writing care plans it may take some time to get things exactly right. However, with each passing week there will be improvement until you are writing care plans with confidence and ease. As you advance through nursing school the academic curriculum and clinical requirements become more challenging. However, although the patients you care for become more complex and, therefore, the care plans more complicated, they actually become easier to write. Learning is based on previous knowledge and experience, and as you progress through nursing school you will find yourself assimilating data more quickly and efficiently, and completing your care plans in a more timely manner. Everyone starts out slowly, but time, practice, and experience will have you writing care plans that not only provide a map of care for your patients, but help you grow as a provider of that care in the profession of nursing.



### *Section Three: Sample Care Plans*

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**Bristol Community College**  
**NUR 11: NURSING CARE PLAN-PHASE I**

Student name:			Patient initials:		Clinical Date		
Rm. #	Admitting Diagnosis	I & O	Diet	Assessments	Tuesday/ Findings	Wednesday/ Findings	
		<u>Tuesday</u>		LOC, Mental Status, Orientation			
Physician		I:  O:	Hygiene	Pain Assessment			
Nurse				Lung Sounds O2 Saturation			
Code status				Bowel Sounds (Assess all 4 quadrants)			
Precautions	Secondary Diagnoses	<u>Wednesday</u>	Activity	Last BM			
Allergies		I:  O:		Extremities (Pulses, OMS, Homan's)			
<b>Treatments/ Procedures</b> List the materials needed and any procedure steps	<b>Specimens to obtain &amp; Diagnostic procedures</b> to be done on your time		<b>Vital Signs</b>		Neurological Checks (PERRLA)		
					IV Therapy Assessments      Ste		
			<b>Tuesday</b>		Flow		
					Complications		
			T		Other		
			P		<b>Medications</b> List all medications that you will administer & times due		
			R				
			B/P				
			<b>Wednesday</b>				
			T		<b>IV Therapy</b> (Solution and Rate)  <u>Scheduled Medications</u> <u>PRN Medications</u>  <u>STAT or One Time</u>		
P							
R							
B/P							

## Definition of Medical Diagnoses and Surgery

### Admitting Diagnosis

**Renal Failure:** the inability of the kidney to excrete wastes, concentrate urine, and conserve electrolytes. The condition may be acute or chronic (Mosby's Medical Dictionary, p. 1485).

Cite your source!

### Secondary Diagnoses

**Angina:** a paroxysmal thoracic pain caused most often by myocardial anoxia as a result of atherosclerosis or spasm of the coronary arteries. The pain usually radiates along the neck, jaw, and shoulder and down the inner aspect of the left arm. Attacks of angina pectoris are often related to exertion, emotional stress, eating, and exposure to intense cold. The pain may be relieved by rest and vasodilation of the coronary arteries by medication (Mosby, p. 96)

**Arthritis:** an inflammatory condition of the joints, characterized by pain, swelling, heat, redness, and limitation of movement (Mosby, p. 136)

**Atrial Fibrillation:** a cardiac arrhythmia characterized by disorganized electrical activity in the atria accompanied by an irregular ventricular response that is usually rapid (Mosby, p. 154)

**Congestive Heart Failure:** an abnormal condition that reflects impaired cardiac pumping. Its causes include myocardial infarction, ischemic heart disease, and cardiomyopathy (Mosby, p. 416).

**Sick Sinus Syndrome (SSS):** a complex of arrhythmias associated with sinus node dysfunction. The condition may result from a variety of cardiac diseases, ranging from cardiomyopathies to inflammatory myocardial disease. It is most commonly related to either intermittent SA block or inadequate SA conduction. Sick Sinus Syndrome is characterized by severe sinus bradycardia, either alone or alternating with tachycardia, or accompanied by atrioventricular block. The most common symptoms are lethargy, weakness, light-headedness, dizziness, and syncope (Mosby, p.1580).

### Surgeries

**Pacemaker:** electrical apparatus used to increase the heart rate in severe bradycardia by electrically stimulating the heart muscle (Mosby, p. 1259).



## NURSING 11 CARE PLAN PHASE TWO

Meds are part of phase 2

Medications		
<b>Name of drug</b> <b>Dose</b> <b>Route</b> <b>Times due</b> <b>Classifications</b> <b>Safe Dose</b>	<b>Drug Action</b>  <b>Reason patient is on medication (be specific)</b>	<b>List 3 side effects</b>  <b>List all significant nursing actions related to the administration of this med</b>
spironalactone      Aldactone 25 mg PO 2x daily 0800/2000 <div style="border: 1px solid black; padding: 2px; color: red; display: inline-block; margin-top: 10px;">Generic and trade names</div>  Pharmacological class: potassium-sparing diuretic  Therapeutic class: management of edema, antihypertensive, diagnosis of primary hyperaldosteronism, treatment of diuretic-induced hypokalemia  Safe dose: up to 100 mg daily	Drug action: antagonizes aldosterone in distal tubule; promotes water and sodium excretion and hinders potassium excretion, lowers blood pressure, and helps to diagnose primary hyperaldosteronism  Reason pt is on med: to treat hypertension  <div style="border: 1px solid black; padding: 5px; color: red; margin-top: 10px;">Number all nursing actions. You will find these listed with each med under "nursing process"</div>	Observe for headache, diarrhea, dehydration  <div style="border: 1px solid black; padding: 5px; color: red; margin-top: 10px;">Always preface side effects with "observe for"</div> 1. Give drug with meals to enhance absorption 2. Protect drug from light 3. Monitor electrolyte levels, fluid intake and output, and BP q shift (0800/1600/2400) 4. Be alert for adverse reactions such as hyperkalemia, angioedema, confusion, and drowsiness 5. Be alert for drug interactions such as potassium chloride
potassium chloride      K-Tab 20 mEq PO daily 0800  Pharmacological class: potassium supplement  Therapeutic class: mineral  Safe dose: up to 50 mEq twice daily	Drug action: aids in transmitting nerve impulses, contracting cardiac and skeletal muscles, and maintaining intracellular tonicity, cellular metabolism, acid-base balance, and normal renal function. Replaces and maintains potassium levels.  Reason pt is on med: CHF  <div style="border: 1px solid black; padding: 5px; color: red; margin-top: 10px;">Note that there may be an interaction between these meds. You may want to emphasize this in red, or by marking it with a highlighter</div>	Observe for EKG changes, abdominal pain, weakness of limbs  1. Give cautiously; different K supplements deliver varying amounts of K. Never switch products without a prescriber's order 2. Give with or after meals with a full glass of water 3. Make sure powders are completely dissolved 4. Monitor renal function, fluid intake and output 5. May interact with K-sparing diuretics

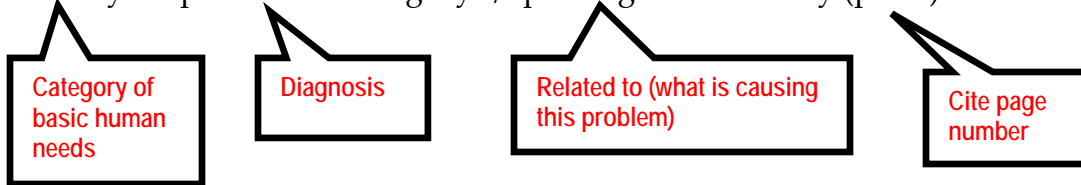
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**NUR 11 NURSING CARE PLAN**  
**THREE MOST IMPORTANT NURSING DIAGNOSES**

Include page number from NUR 11 required nursing diagnosis book

**Tuesday**

1. Oxygenation: Decreased Cardiac Output r/t dysrhythmia (p.136)
2. Elimination: Impaired Urinary Elimination r/t diuretic therapy (p.787)
3. Safety: Impaired Skin Integrity r/t prolonged immobility (p.584)



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**Wednesday**

- 1.
- 2.
- 3.

Your diagnoses may remain the same or, after you have reassessed the patient, change for day 2.

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**Implications for Nursing Care Related to Cultural Background**  
(consider language, religion, ethnicity, and social organization)

Patient is English-speaking and lives alone in a single story house and receives meals daily from Meals on Wheels. She is a retired nurse and is active in her community. She is a devout Roman Catholic and attends Mass regularly.

**THIS IS PART OF PHASE TWO**

Nursing Diagnosis	Nursing Interventions
<p>Decreased Cardiac Output r/t dysrhythmia (Carpenito, p.136)</p> <div data-bbox="259 405 532 621"> <p>List all assessments you will perform. Be specific about times.</p> </div> <div data-bbox="235 1121 540 1255"> <p>List the specific labs you will monitor</p> </div> <div data-bbox="245 1656 534 1791"> <p>List specific meds related to this diagnosis</p> </div>	<p><b>Assessments</b></p> <ol style="list-style-type: none"> <li>1. Assess rate and quality of apical and peripheral pulses q shift @ 0800, 1600, 2400</li> <li>2. Assess BP and any orthostatic changes q shift @ 0800, 1600, 2400, and before ambulating patient</li> <li>3. Assess lung sounds q shift @0800, 1600, 2400. Note any occurrence of orthopnea</li> <li>4. Assess for complaints of fatigue and reduced activity tolerance. Determine what level of activity causes fatigue or exertional dyspnea</li> <li>5. Assess urine output q shift @ 0800, 1600, 2400</li> <li>6. Assess for any changes in mental status while performing neuro checks q shift @ 0800, 1600, 2400</li> <li>7. Assess oxygen saturation with pulse oximetry q shift @ 0800, 1600, 2400 and during activity</li> </ol> <p><b>Interventions</b></p> <ol style="list-style-type: none"> <li>1. Monitor and record intake and output q shift @ 0800, 1600, 2400</li> <li>2. Monitor for symptoms of heart failure and decreased cardiac output; listen to heart and lung sounds; note any orthopnea, dyspnea, fatigue, weakness, adventitious lung sounds such as crackles or rales</li> <li>3. Observe for chest pain or discomfort; note location, radiation, severity, quality, duration, and associated manifestations such as nausea, indigestion, and diaphoresis; also note precipitating and relieving factors.</li> <li>4. Monitor lab work such as CBC, sodium, potassium, and creatinine level</li> <li>5. Gradually increase activity when the patient's condition is stabilized by encouraging slow-paced or short periods of activity with frequent rest: observe for symptoms of intolerance <ol style="list-style-type: none"> <li>a) Take BP and pulse before and after activity and note changes</li> </ol> </li> <li>6. Monitor bowel function. Administer colace 100 mg PO daily @0800, as prescribed <ol style="list-style-type: none"> <li>a) Caution patient not to strain when defecating</li> <li>b) Have her use the commode for toileting and avoid use of bedpan</li> </ol> </li> <li>7. Observe for syncope, dizziness, palpitations, or feelings of weakness associated with an irregular heart rhythm</li> <li>8. Administer spironolactone 25 mg PO @ 0800; potassium chloride 20 mEq PO @ 0800 as prescribed</li> <li>9. Observe for side effects from cardiac medications</li> </ol> <p><b>Teaching</b></p> <ol style="list-style-type: none"> <li>1. Teach stress reduction techniques such as guided imagery,</li> </ol>



<div data-bbox="245 296 540 453" data-label="Text"> <p>Reference to volunteer work is specific to this patient.</p> </div>	<p>controlled breathing, muscle relaxation</p> <ol style="list-style-type: none"> <li>2. Explain necessary restrictions, including the need for a sodium-restricted diet, guidelines on fluid intake, and the avoidance of the Valsalva maneuver</li> <li>3. Teach the importance of pacing activities, including volunteer work, and the need to rest between activities to prevent becoming over-fatigued</li> <li>4. Teach her about the actions, side effects, and importance of taking cardiovascular medications</li> <li>5. Provide specific written materials and self-care plan for her, or her caregivers, to use as a reference</li> <li>6. Instruct her on the importance of getting a pneumonia vaccine (usually once per lifetime) and flu vaccines (yearly) as prescribed by her physician</li> </ol>
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**THIS IS INCLUDED IN PHASE THREE**

### **Med-Surg: Nursing 51 & 52 Care Plans**

Following is a sample of a nursing 51 medical-surgical care plan. You will notice that it contains more extensive information than the NUR 11 care plan and is quite different in format from the OB and pediatric care plans.

As with NUR 11, your interventions must be broken down into sections. However, for med-surg they should appear as follows: Assess, Prevent, and Evaluate. Under Assess you will list, of course, all necessary assessments for that diagnosis. Under Prevent, list all interventions you plan to perform in order to prevent further deterioration of, and hopefully improve, your patient's condition and well-being. Under Evaluate you will list the expected outcomes for your diagnosis.

In order to give you a comprehensive picture of what your care plan should look like, the sample I have provided is presented in its entirety.

**BRISTOL COMMUNITY COLLEGE**  
Fall River, MA  
**CARE PLAN**  
**NUR 51 & 52**

<b>Name:</b>	<b>Patient's initials:</b>	<b>Diagnosis:</b> cellulitis, L upper thigh
<b>Date:</b>	<b>Age:</b> 44	<b>Surgery:</b> N/A
<b>Admission Date:</b>	<b>Allergies:</b> morphine, cephalosporins	<b>Date of surgery:</b> N/A

**Significant Past History (including social history)**

Patient is a married 44 y/o female. History reveals a recent cervical spine infection resulting in a fracture and subsequent quadriplegia. The c-spine infection is speculated to have arisen from an undiagnosed cyst which burst. Patient had a long hospitalization followed by recuperation at \_\_\_\_\_ Nursing Home, where she has been residing for the last 2 months. Her husband is disabled and they recently lost their home, due to their respective medical conditions and financial hardship. Their 2 adolescent children are staying with relatives. There is a distant hx of drug abuse which predates the c-spine infection by several years. Patient identifies her religion as Catholic. She is a full code, as there are no advance directives in place at this time.

**Reason for Present Admission**

Patient has pressure ulcers on both shoulder blades, coccyx, and R hip. Her left hip and the anterior and lateral aspects of the L thigh are red, edematous, and warm to the touch. She was complaining of neck spasms, more pronounced on the left than the right. She developed a fever, her mental status appeared to deteriorate and she was brought to the ER at \_\_\_\_\_ Hospital. Her temperature was recorded at 103.5. A lumbar puncture was performed; the results were negative for meningitis. She complains of not feeling well, and being "achy all over" x3-4 days. There is some distension of the abdomen, but there have been no changes in bowel habits. Diagnosis is cellulitis of the L upper thigh.

D5NS @100 cc/hr  
Foley catheter  
Regular diet  
Flush G-tube with 30 cc H2O before and after meds  
Coccyx: aqua gel with 1" roll of gauze, cover with DSD

This information will be found on the Kardex. There is not a specific place for it on your care plan, so you may write it in anywhere.  
TIP: orders and treatments such as these can change at any time – it is best to re-check the Kardex on the morning of clinical, and write these on your care plan when you come in, rather than typing them in the night before.

### Significant Events Since Admission

Date: CXR reveals cephalization with interstitial opacities. May reflect volume overload or underlying interstitial lung disease. No pleural effusion, consolidation or pneumothorax.

Date: Attempt to insert PICC line to left antecubital region unsuccessful after 3 attempts. Nurse to consult with MD about alternative options

Date: Patient completed assessment forms for pain clinic. Awaiting assessment by wound clinic and PT/OT

Date: Triple lumen central line placed RUC. Placement checked by portable CXR

### Summary of Patient Status at End of Day 1

Vital signs: 0700 101.3 – 77 – 16 94/59 95%RA  
1130 101.1 – 75 – 17 89/54 97%RA

This section consists of the findings of your head-toe physical assessment.

Patient alert & oriented x3 for most of the day, with periodic naps. Lungs are clear bilaterally; abdomen soft with positive bowel sounds x4 quadrants. Calves appear normal with no redness, edema, or warmth; positive bilateral pedal pulses. There is a small area of redness on the tip of the R great toe, which I outlined with marker, nurse made aware. Heels intact with no redness. Skin is dry with some flaking. Lips are dry, but inspection of the oral mucous membranes shows adequate moisture and no lesions. There is marked redness and heat over the L hip and the anterio-lateral aspect of the L upper thigh related to the cellulitis. Entire area circled by nurse, in order to evaluate any recession or progression. Wound to coccyx not inspected, as patient is awaiting a consult from the wound clinic. Dry, sterile 4x4 replaced over 1cm circular wound on R shoulder blade; some serosanguinous drainage present. Patient c/o discomfort of her neck and back; performed frequent position changes, taking care to ensure proper body alignment. Area around Foley catheter inspected and cleaned; no redness, edema, discharge or odor present. IV site on R hand patent. Patient c/o burning and itching while Unasyn being infused. Site inspected by nurse; no change of temperature or color of skin, no edema. Infusion slowed and warm pack applied to site. Patient ate 100% of breakfast, 30% of lunch. PO fluid intake was approximately 860 cc's. Urine output of 450cc's (64 cc/hr), appearance yellow and concentrated. Patient had 1 large bowel movement mid-morning. Afternoon vitals revealed patient to be febrile @ 101.1 with a BP of 89/54. Nurse made aware and informed me that BP consistently runs low. An order for Tylenol 1000 mg PO q 6 hours was written today.

#### **Day 2:**

Vitals: 0700 99.7 – 80 – 20 102/69 96%RA  
1100 98.7 – 74 – 18 122/69 96%RA

Vancomycin: peak 32.6, trough 8.0

Wound care consult: treatment plan is to change dsg to coccyx 2x day. Irrigate with sterile H<sub>2</sub>O, coat packing with triple antibiotic, cover with DSD.

**You should also list your day 2 labs!**

Your day 2 vitals and any new treatments will be written in by hand before you pass in your care plan

In order of priority; may  
change for day 2

Priority		Nursing Diagnosis	Objective Test Data		
W	TH		Test & Norms	Results & Dates	Interpretation
1	1	Impaired Skin Integrity r/t immobility, pressure	Sodium 135-145	2-13: <b>131</b> 2-14: <b>135</b>	Slightly decreased due to sweating (febrile x3 days), deficient dietary intake Slightly decreased with sodium loss
2	2	Risk for Infection r/t open wounds	Chloride 96-107	2-13: <b>96</b> 2-14: <b>102</b>	
3	3	Risk for Ineffective Tissue Perfusion, peripheral r/t interrupted venous flow secondary to prolonged immobility	Potassium 3.5-5	2-14: <b>3.2</b>	
4	4	Powerlessness r/t loss of function	Glucose 70-110	2-13: <b>121</b>	Slightly elevated; may be r/t meds
5	5	Chronic Sorrow r/t permanent disability	BUN 8-21	2-13: <b>5</b> 2-14: <b>5</b>	Decreased; may be due to low protein intake, malnutrition
6	6	Chronic Pain r/t disease process	Creatinine 0.5-1.2	2-13: <b>0.4</b> 2-14: <b>0.3</b>	Decreased due to low protein, decreased muscle mass, malnutrition
7	7	Disturbed Body Image r/t trauma (quadriplegia)	Prealbumin 18-36	2-13: <b>17.7</b>	Decreased due to low protein, malnutrition
8	8	Ineffective Protection r/t abnormal blood profile (see labs)	Protein (CSF) 15-45	2-13: <b>45.8</b>	Not significant. Level must be moderately to markedly increased to suggest infection
9	9	Impaired Bed Mobility r/t neuromuscular impairment (classification level 4: does not participate in activity)	WBC 3-11	2-13: <b>15.4</b> 2-14: <b>7.3</b>	Acute infection (cellulitis)
10	10	Imbalanced Nutrition, less than body requirements r/t loss of appetite (wgt: 125 lbs BMI: 20.2)	MCV 82-96	2-13: <b>80.2</b> 2-14: <b>81.7</b>	RBC's are slightly microcytic
11	11	Self-care Deficit, bathing/hygiene, dressing/grooming, toileting r/t neuromuscular impairment	Neutrophils 42-83%	2-13: <b>88%</b>	Acute, localized infection, inflammation
			Lymphocytes 13-47%	2-13: <b>5%</b> 2-14: <b>6.9%</b>	Decreased; may be due to debilitating illness

Include  
specifics

12	12	Sexual Dysfunction r/t altered body function	Urine pH 5-6	2-13: >9	May be r/t potassium loss
13	13	Deficient Diversional Activity r/t disability, environment	RBC 3.96-5.27	2-14: 3.78	Related to iron deficiency
14	14	Risk for Autonomic Dysreflexia r/t spinal injury	HGB 11.6-15.5	2-14: 10.5	Due to anemia
15	15	Risk for Disuse Syndrome r/t paralysis	HCT 35-47	2-14: 30.9	Indicates anemia. Likely iron-deficient (if microcytic, RBC's and HCT do not parallel)

Although not required, you may want to type lab values in a different color, or mark them with a highlighter to help them stand out for easy reference.

Nursing Priorities for Day 1	Evaluation of Priority Achievement	Nursing Priorities for Day 2
<p>Impaired Skin Integrity r/t immobility, pressure on bony prominences</p> <div data-bbox="188 380 558 543" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Evaluate whether your diagnosis was, or was not, appropriate, and why</p> </div> <p>Risk for Infection r/t open wounds</p> <p>Risk for Ineffective Tissue Perfusion, peripheral r/t interrupted venous flow secondary to prolonged immobility</p> <p>Powerlessness r/t loss of function</p>	<p>This was an accurate diagnosis and important priority. Patient has an open wound on the coccyx, and wounds on both shoulder blades. Her immobility presents a challenge in that it may be difficult to promote healing and prevent new wounds, as the pt is almost constantly on her back.</p> <p>Patient at increased risk for infection of her wounds, particularly the one on her coccyx due to its depth and proximity to the anus (she is occasionally incontinent of stool)</p> <p>I am not entirely confident that this diagnosis is a top 5 priority. There are others which could easily move up the list. Patient is being treated with Lovenox 40 mg SC daily; however, she is unable to perform ROM exercises, and the absence of compression stockings concerns me. Development of a DVT and progression to a pulmonary embolism is a real danger . . . symptoms could develop silently, as the pt is unable to report changes in sensation</p> <p>Powerlessness is a huge issue with this pt. She demonstrates behaviors at the low, moderate, and severe level. Her lack of function is only one contributing factor (she is completely dependent on others for care). An equal portion is directly related to her perceived lack of control over decisions and what happens to her. She has been</p>	<p>This remains a priority at #1. I would like to view and measure her existing wounds, if the wound consultant has not done so (pt due for consult on day one, after I left)</p> <p>This diagnosis remains at #2, for the reasons stated. I will check her frequently for incontinence and clean her promptly to avoid contamination of her wound</p> <p>I will keep this diagnosis at #3, above powerlessness and chronic sorrow, only because it is potentially life-threatening. I will speak to her primary nurse about obtaining an order for TEDS or pneumatic stockings</p> <div data-bbox="1094 1224 1442 1499" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>If your diagnosis remains the same, what do you plan to do for the pt on day 2? If it changes, list the new one in this column and provide a rationale for the change</p> </div> <p>This diagnosis remains at #4. I would like to initiate a consult with a psychiatric nurse as well as make inquiries about her possible options for a different care facility (she mentioned a facility where she felt better cared for).</p>

<p>Chronic Sorrow r/t permanent disability</p>	<p>unsuccessful in her attempts to gain information about her treatment goals and discharge plans, particularly as it applies to the nursing home where she currently resides. She feels ignored and seems resigned that it is useless to attempt to gain information. She appears to have an external locus of control.</p> <p>Patient exhibits behaviors consistent with this diagnosis. She has periods of sadness, crying, anger, frustration, apathy, etc. I'm concerned that she is suffering from major clinical depression.</p>	<p>This diagnosis stays at #5. I would like to explore with the patient her feelings about counseling/medication for depression. I wonder if a combination of consistent cognitive-behavioral therapy and antidepressant medication might promote readiness for enhanced coping.</p>
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Medication Order	Rationale for use in this patient	Nursing Care Measures
<p>fentanyl patch                      Duragesic 100 mcg transdermal q 3 days Opioid analgesic Anesthetic MOA: may bind with opioid receptors in CNS, altering both the perception of and emotional response to pain</p> <div data-bbox="147 499 589 625" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Patient is taking these types of meds also – list in another color or mark with a highlighter!</p> </div> <p>Safe dose: 100 mcg per hour</p>	<p>For pain relief</p> <p>May interact with: <b>CNS depressants, other opioid analgesics, diazepam</b> (CV depression may occur)</p> <p>Side effects: confusion, hallucinations, arrhythmias, bradycardia, dry mouth, urine retention, respiratory depression, apnea</p>	<p>1. Monitor bladder function, respiratory rate and depth, and O2 saturation 2. Report respirations of &lt;12/minute, O2 sat of &lt;95%</p> <div data-bbox="1081 415 1438 695" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Notice that any teaching r/t applying the fentanyl patch has not been included - patient is a quadriplegic and unable to apply it herself. Teaching would be directed at family/caregivers, if appropriate</p> </div>
<p>zinc sulfate                              Zinca-Pak 220 mg PO daily Trace element Nutritional agent MOA: participates in synthesis and stabilization of proteins and nucleic acids in subcellular and membrane transport systems</p> <p>Safe dose: 660 mg daily</p>	<p>To promote healing of wounds</p> <p>No significant interactions</p> <p>Side effects: N/V</p>	<p>1. Monitor serum zinc levels. Normal range is 0.05 – 0.15 mg/dL</p>
<p>enoxaparin sodium                      Lovenox 40 mg SC daily Low-molecular-weight heparin derivative Anticoagulant MOA: accelerates formation of antithrombin III-B-thrombin complex and deactivates thrombin, preventing conversion of fibrinogen to fibrin. Has higher antifactor Xa-antifactor IIa activity ratio</p> <p>Safe dose: 40 mg SC once daily for 6-11 days; up to 14 days can be tolerated</p>	<p>To prevent DVT, pulmonary embolism</p> <p>Side effects: peripheral edema, CV toxicity, hypochromic anemia, thrombocytopenia, hemorrhage, bleeding complications, redness/irritation at injection site</p>	<p><b>For severe overdose, give protamine sulfate by slow IV infusion at concentration of 1% to equal dosage of enoxaparin injected</b></p> <p>1. Monitor platelet count 2. To avoid drug loss do not expel air bubble from 30- or 40-mg prefilled syringes 3. Do not massage after SC injection. Rotate sites among the L and R anterolateral and the L and R posterolateral abdominal walls 4. Monitor pt for s/s of bleeding</p>
<p>lorazepam                                      Ativan 0.5 mg PO 3X daily Benzodiazepine, sedative hypnotic, antianxiety agent, anticonvulsant, skeletal muscle relaxant, antiemetic MOA: inhibits ability to recall events. Interacts with GABA-benzodiazepine receptor complex in the brain</p> <p>Safe dose: up to 10 mg daily</p>	<p>To prevent/reduce anxiety</p> <p>May interact with other CNS depressants</p> <p>Side effects: airway obstruction, apnea, blurred vision, confusion, crying, delirium, depression, excessive drowsiness, hypotension, respiratory depression, hypotonia,</p>	<p>1. Monitor liver, kidney, and hematopoietic function periodically</p>

Generic name not capitalized

<p>pantoprazole sodium      Protonix 40 mg PO daily Proton pump inhibitor, gastric acid suppressant MOA: inhibits the activity of the proton pump by binding to hydrogen-potassium adenosine triphosphate, located at secretory surface of the gastric parietal cells. Suppresses gastric acid secretion</p> <p>Safe dose: 40 mg daily x8 weeks</p>	<p>To treat GERD</p> <p>Side effects: headache, insomnia, asthenia, migraine, anxiety, dizziness, diarrhea, abd. pain, constipation, urinary frequency, UTI, back pain, neck pain, bronchitis, increased cough</p>	<p>1. Monitor for signs of epigastric or abdominal pain, and for blood in stool or emesis 2. Tablet must be swallowed whole and not crushed, split, or chewed 3. Give with or without food</p>
<p>docusate sodium      Colace 100 mg PO 2X daily Emollient laxative MOA: reduces surface tension of interfacing liquid contents of bowel; promotes additional liquid into stool, thus forming a softer mass</p> <p>Safe dose: up to 360 mg daily</p>	<p>To prevent/relieve constipation</p> <p>Side effects: mild cramping, diarrhea</p>	<p>1. Teach patient about maintaining adequate fluid and fiber intake</p>
<p>ascorbic acid      Vitamin C 500 mg PO daily Water-soluble vitamin MOA: stimulates collagen formation and tissue repair; involved in oxidation-reduction reactions throughout the body</p> <p>Safe dose: up to 500 mg daily for patients with delayed wound healing</p>	<p>To promote healing</p> <p>Side effects: diarrhea, acid urine, renal calculi</p>	<p>1. Give PO solution directly into mouth or mix with food 2. Teach patient about dietary sources of Vitamin C</p>
<p>levothyroxine      Synthroid 125 mcg PO daily Thyroid hormone replacement MOA: not fully defined; stimulates metabolism by accelerating cellular oxidation</p> <p>Safe dose: up to 200 mcg daily</p>	<p>To treat hypothyroidism</p> <p>Side effects: tachycardia, palpitations, HTN, dysphagia,</p>	<p>1. Monitor TSH levels 2. Give drug at the same time each day, to keep hormone level constant 3. Instruct pt to immediately report chest pain, palpitations, sweating, or shortness of breath</p>
<p>vancomycin HCl      Vancocin 1 GM IV in NS q 12 hours Glycopeptides Antibiotic MOA: hinders bacterial cell wall synthesis, damaging bacterial plasma membrane and making cell more vulnerable to osmotic pressure</p> <p>Safe dose: up to 1000 mg q 12 hours (2000 mg daily)</p>	<p>To treat staph infection (cellulitis of L upper thigh)</p> <p>Patient's specific infection.</p> <p>Side effects: tinnitus, ototoxicity, nephrotoxicity, wheezing, dyspnea, red man syndrome</p>	<p>IV Administration Dilute in 200 ml NS Infuse over 60 minutes Do not infuse with any other medications</p> <p>Always include instructions for giving a med intravenously</p> <p>1. Monitor peaks and troughs 2. Monitor site for phlebitis/irritation/infiltration/extravasation</p>

<p>ampicillin sodium (1GM) and sulbactam sodium (0.5GM) Unasyn</p> <p>1.5 GM IV q 6 hours</p> <p>Aminopenicillin and beta-lactamase inhibitor</p> <p>Antibiotic</p> <p>MOA: ampicillin inhibits cell-wall synthesis during microorganism multiplication; sulbactam inactivates bacterial beta-lactamase, the enzyme that inactivates ampicillin and provides bacterial resistance to it</p> <p>Safe dose: up to 3GM q 6 hours (12 GM daily)</p>	<p>To treat skin structure infection (cellulitis of L thigh)</p> <div data-bbox="634 279 987 520" style="border: 2px solid black; padding: 5px; margin: 10px 0;"> <p>Patient did experience vein irritation; because of my med research, I was prepared for this possibility. See summary of pt status at end of day 1.</p> </div> <p>Side effects: vein irritation, thrombophlebitis, anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis</p>	<p><u>IV Administration</u></p> <p>Reconstitute with: NS, D5W, or LR</p> <p>Allow to stand a few minutes to allow foam to dissipate</p> <p>Inject over 10-15 minutes or dilute in 50-100 ml of a compatible diluent and infuse over 15-30 minutes</p> <p>Change site q 48 hours</p> <p>Do not add or mix with other drugs</p>
<p>oxycodone CR</p> <p>40 mg PO q 8 hours</p> <p>Opioid analgesic</p> <p>MOA: same as fentanyl</p> <p>Safe dose: up to 80 mg q 12 hours</p>	<p>For moderate to severe pain</p> <p>May interact with: <b>other opioid analgesics (fentanyl)</b></p> <p>Side effects: hypotension, bradycardia, constipation, ileus, urine retention, respiratory depression</p>	<ol style="list-style-type: none"> <li>1. Monitor rate and depth of respirations; if &lt;12, report immediately</li> <li>2. Give with food or milk to prevent GI upset</li> <li>3. Assess pain using a pain rating scale before and after administration</li> </ol>
<p>multivitamin</p> <p>1 cap PO daily</p> <p>Nutritional supplement</p>	<p>Multivitamins are prescribed for patients who need extra vitamins, who cannot eat enough food to obtain the required vitamins, or who cannot receive the full benefit of the vitamins contained in the food they eat</p>	
<p>citalopram hydrobromide Celexa</p> <p>40 mg PO daily</p> <p>SSRI</p> <p>MOA: may enhance serotonergic activity in CNS by inhibiting neuronal reuptake of serotonin</p> <p>Safe dose: up to 40 mg daily</p>	<p>To treat depression</p> <p>Side effects: confusion, tachycardia, dry mouth, taste perversion, upper respiratory infection, increased sweating</p>	<ol style="list-style-type: none"> <li>1. Monitor VS regularly for signs of decreased BP or tachycardia</li> </ol>

Medication Order	Rationale for use in this patient	Nursing Care Measures
<p>diazepam Valium 1 mg PO q 6 hours prn Benzodiazepine Anxiolytic, skeletal muscle relaxant, anticonvulsant, sedative-hypnotic MOA: may depress CNS at limbic and subcortical levels of brain; suppresses spread of seizure activity produced by epileptogenic foci in cortex, thalamus, and limbic system</p> <p>Safe dose: up to 40 mg daily</p>	<p><b><u>PRN's</u></b></p> <p>To treat anxiety or muscle spasms</p> <p>May interact with: <b>CNS depressants</b></p> <p>Side effects: hangover, ataxia, psychosis, tremors, bradycardia, CV collapse, diplopia, urine retention, respiratory depression, desquamation</p>	<p>1. Monitor pulse and rate and depth of Respirations 2. Report pulse &lt;60 or respirations &lt;12</p>
<p>acetaminophen Tylenol 650 mg PO q 6 hours prn Non-opioid analgesic MOA: analgesic effects by blocking prostaglandins or pain receptor sensitizers May relieve fever by acting in hypothalamic heat regulating center Relieves pain and fever</p> <p>Safe dose: up to 4000 mg daily</p>	<p>As needed for discomfort or fever</p> <p>Side effects: neutropenia, leukopenia, thrombocytopenia, liver damage, hypoglycemia, jaundice</p>	<p><b>Antidote: acetylcysteine initially 140 mg/kg PO followed by 70 mg/kg PO q 4 hours for 17 doses</b></p> <p>1. Carefully monitor all sources of acetaminophen to ensure that administration does not exceed 4000 mg daily</p>
<p>oxycodone HCl OxyContin 10 mg PO q 4 hours prn OR 5 mg PO q 4 hours prn Opioid analgesic MOA: same as fentanyl, oxycodone CR</p> <p>Safe dose: 5 mg q 6 hours (20 mg/24 hours) <b>This dose is not safe</b> (pt may have tolerance)</p>	<p>For moderate to severe pain</p> <p>May interact with: <b>CNS depressants</b></p> <p>Side effects: hypotension, bradycardia, constipation, ileus, urine retention, respiratory depression</p>	<p>Nursing actions same as for oxycodone CR</p>

PRIORITY DIAGNOSES	NURSING INTERVENTIONS	RATIONALES
<p>Impaired Skin Integrity r/t immobility, pressure over bony prominences</p> <p>Subjective/Objective data: Redness, moisture, broken skin, open areas, drainage</p> <div> <p>These are the s/s that you directly observe or that are reported by the patient</p> </div>	<p><u>Assess</u></p> <ol style="list-style-type: none"> <li>1.Site(s) of skin impairment at least once daily for signs of infection (color changes, redness, warmth, swelling, exudate, odor)</li> <li>2.Patient's continence status</li> <li>3.Nutritional status (weight, calories, protein, CHO, fats, vitamins, minerals, prealbumin)</li> </ol> <p><u>Prevent</u></p> <ol style="list-style-type: none"> <li>1.Measure size and depth of wound. Determine that impairment involves skin damage only. Classify as Stage I or II</li> <li>2.Minimize exposure of skin impairment and other areas to moisture from incontinence, perspiration, or wound drainage</li> <li>3.Initiate a PT consult to conduct a risk assessment tool to systematically assess immobility-related risk factors</li> <li>4.Avoid positioning patient on site of impairment (coccyx)</li> <li>5.Turn and reposition q 2 hours</li> </ol>	<ol style="list-style-type: none"> <li>1.Systematic inspection can identify impending problems early</li> <li>2.Moisture from incontinence contributes to pressure ulcer development by macerating the skin</li> <li>3.Optimizing nutritional intake is needed to promote wound healing</li> </ol> <div> <p>Citations not required in NUR 51</p> </div> <ol style="list-style-type: none"> <li>1.Establishes a baseline for comparison when evaluating healing</li> <li>2.Moisture contributes to pressure ulcer development by macerating the skin</li> <li>3.A validated risk assessment tool such as the Norton or Braden scale should be used to identify patients at risk for immobility-related breakdown and to help guide the plan of prevention and care</li> <li>4.Creates pressure and interferes with perfusion</li> <li>5.Alternates sites of pressure relief and keeps the patient</li> </ol>

<div data-bbox="136 630 493 760"> <p>Physician's specific order for dressing changes</p> </div> <div data-bbox="126 1031 466 1096"> <p>Expected outcome</p> </div>	<div data-bbox="514 324 1249 990"> <p>6.Transfer patient with care to avoid external mechanical forces (pressure, friction, shear)</p> <p>7.Maintain HOB at lowest possible degree of elevation</p> <p>8.Use lift devices, pillows, foam wedges to assist patient with moving and positioning</p> <p>9.Apply wound gel daily; pack with 1"roll of gauze and cover with DSD</p> <p>10.Avoid massaging around wound sites and over bony prominences</p> <p>11.Identify the phase of wound healing (inflammation, proliferation, maturation)</p> </div> <div data-bbox="514 1031 1087 1104"> <p><u>Evaluate</u></p> <p>1.Patient will regain integrity of skin surface</p> </div>	<div data-bbox="1312 243 2005 990"> <p>comfortable</p> <p>6.Prevents skin damage</p> <p>7.Having HOB at &lt;30 degrees minimizes shearing of tissues caused by sliding down in bed</p> <p>8.To maintain alternative positions and pad bony prominences</p> <p>9.Physician's order. Promotes healing and protects wound</p> <p>10.This can result in deep tissue damage</p> <p>11.Accurate understanding of tissue status provides a basis for determining appropriate treatments.</p> </div>
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PRIORITY DIAGNOSES	NURSING INTERVENTIONS	RATIONALES
<p>Risk for Infection r/t open wounds</p> <p>Subjective/Objective data: Elevated temp., redness, warmth, edema, prurulent drainage, odor, abnormal lab values, positive cultures</p>	<p><u>Assess</u></p> <ol style="list-style-type: none"> <li>1. Temperature q shift and prn</li> <li>2. For redness, warmth, edema, exudates, odor, elevated temperature</li> <li>3. Skin for moisture, texture, and turgor</li> <li>4. Nutritional status (weight, calories, protein, CHO, fats, vitamins, minerals)</li> </ol> <p><u>Prevent</u></p> <ol style="list-style-type: none"> <li>1. Monitor lab values (WBC, differentials, prealbumin, serum albumin, cultures)</li> <li>2. Wash and thoroughly dry skin (pat, don't rub). Take particular care with skin folds</li> <li>3. Encourage a balanced diet. Emphasize proteins, vitamins (A, B6, B12, C, E), folic acid, linoleic acid, zinc</li> <li>4. Give 1 tablet multivitamin PO daily @0800</li> <li>5. Give zinc sulfate 220 mg PO daily @0800</li> <li>6. Administer Vancocin 1GM IV q 12 hours @0600/1800 and Unasyn 1.5GM IV q 6 hours @0200/0800/1400/2000</li> </ol>	<ol style="list-style-type: none"> <li>1. Elevated temperature is a sign of infection</li> <li>2. These are indications of infection</li> <li>3. Intact skin is nature's first line of defense against microorganisms entering the body</li> <li>4. Optimizing nutritional intake is needed to promote wound healing</li> </ol> <ol style="list-style-type: none"> <li>1. Lab values provide a global view of patient's immune function</li> <li>2. Maintaining supple skin is best method for keeping skin intact</li> <li>3. These nutrients are required for efficient functioning of the immune system</li> <li>4. Physician's order. Promotes healing</li> <li>5. Physician's order. Promotes healing</li> <li>6. Physician's order. Treats infection</li> </ol>

Physician's specific med orders, including dose, route, and times

	<p>7.Take measures to prevent nosocomial infections (frequent hand washing, sterile dressing changes, standard precautions)</p> <p>8.Encourage fluid intake, if not contraindicated</p> <p><u>Evaluate</u></p> <p>1.Patient will become free of infection</p> <p>2.Patient's WBC count will return to normal parameters</p>	<p>7.Hospital-acquired infections increase morbidity and mortality</p> <p>8.Fluid intake helps thin secretions and replace fluid lost during fever</p>
<p>Risk for Ineffective Tissue Perfusion, peripheral r/t interrupted blood flow secondary to prolonged immobility</p> <p>Subjective/Objective data: Redness, warmth, edema, increase in circumference of calf or thigh, absent pedal pulses, cool/pale extremity</p>	<p><u>Assess</u></p> <p>1.Calves and thighs for redness, warmth, edema, venous dilation; also coolness, pallor, edema distal to inflammation</p> <p>2.Pedal pulses</p> <p><u>Prevent</u></p> <p>1.Perform passive ROM exercises</p> <p>2.Encourage deep breathing</p> <p>3.Measure calves and thighs daily while patient is supine. Monitor for increased circumference</p>	<p>1.These are indicators of DVT</p> <p>2.Absent or diminished pedal pulses indicate arterial insufficiency</p> <p>1.To increase circulation, which will promote peripheral perfusion</p> <p>2.Increases negative pressure in the lungs and thorax to promote emptying of large veins, thus increasing peripheral perfusion</p> <p>3.To assess for extremity enlargement caused by DVT. An increase of &gt;2cm in 1 day is significant, as well as calf</p>

Ackley indicated both active and passive ROM – only passive is listed due to pt's quadriplegia – this makes the intervention specific to the pt



	<p>4.Consult physician about use of antiembolism stockings</p> <p>5.Increase fluid intake to at least 2-3L/day, if not contraindicated</p> <p>6.Give Lovenox 40 mg SC daily</p> <p><u>Evaluate</u></p> <p>1.Patient will maintain adequate peripheral perfusion as evidenced by normal skin color, temperature, and positive bilateral pedal pulses</p>	<p>diameter &gt;3cm larger than the other calf</p> <p>4.Compression stockings help prevent DVT in hospitalized patients</p> <p>5.To reduce hemoconcentration, which can contribute to development of DVT</p> <p>6.Physician's order. Prevention of DVT</p>
<p>Powerlessness r/t loss of function</p> <p>Subjective/Objective data: Crying, passivity, irritability, guilt, frustration, verbalization of having no control</p>	<p><u>Assess</u></p> <p>1.<b>Low:</b> expressions of uncertainty, passivity</p> <p>2.<b>Moderate:</b> nonparticipation in care or decision-making when opportunities are provided; resentment, anger, and guilt; reluctance to express true feelings; passivity; dependence on others that may result in irritability; feeling alienation from caregivers; expressions of dissatisfaction and frustration because of inability to perform previous tasks/activities; expression of doubt regarding role performance; does not monitor progress; does not defend self-care practices when challenged; inability to seek</p>	<p>It is necessary to determine the level of powerlessness the patient is experiencing so that the nurse can choose appropriate interventions.</p> <p>This patient exhibits behaviors from all three levels.</p>

	<p>information regarding care</p> <p>3.<b>Severe:</b> verbal expression of having no control over self-care, or influence over situation, or influence over outcomes; apathy; depression regarding physical deterioration that occurs despite patient's compliance with regimen</p> <p>4.Assess my own philosophies of care to ensure that control issues or lack of faith in the patient's capabilities will not bias my ability to intervene sincerely and effectively</p> <p><u>Prevent</u></p> <p>1.Be alert for behaviors that attempt to assert power, even if they seem confrontational. Assist patient to channel those behaviors in an effective manner</p> <p>2.Determine the patient's locus of control related to her health</p> <p>3.Establish a therapeutic relationship (spend one-on-one time with her, keep commitments, provide encouragement, listen attentively, be empathetic)</p> <p>4.Allow patient to share her feelings</p> <p>5.Encourage participation in self-care and self-management</p>	<p>4.Professional self-reflection is an important element in the maintenance of an empowerment philosophy. Such reflection helps the nurse come to terms with the cognitive dissonance of trying to empower patients within organizations (health care system) that are inherently disempowering</p> <p>1.Patient is looking for a measure of control. Assisting her to channel her energies appropriately is empowering.</p> <p>2.An external locus of control can lead a patient to believe that she has no power over a situation</p> <p>3.Powerlessness is heightened when there is a sense of distance, violation, or disconnection</p> <p>4.Listening to the patient reduces her frustration</p> <p>5.The more a patient participates in her own care, the</p>
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Note the specificity – you would not place the phone, food, or drink within reach because this patient is unable to move. She is, however, able to grasp items and use her fingers

of illness. Have her assist in planning care whenever possible

6.Keep items the patient needs, wants, and is able to use within reach (tissues, call light, television remote – patient is able to use her fingers)

7.Give realistic and sincere praise for accomplishments

8.Acknowledge subjective concerns or fears

Evaluate

1.Patient will state feelings of powerlessness and other feelings related to powerlessness

2.Patient will participate in planning and implementing care, and make decisions regarding care and treatment when possible

3.Patient will verbalize hope for the future

less powerless they feel

6.Well-being can be affected much more by choices related to activities of daily living. Patient is able to participate in her own care if devices are accessible

7.Giving realistic praise assists the patient in developing positive feelings and enhances self-concept

8.All feelings are personal and have meaning for the patient

<p>Chronic Sorrow r/t permanent disability</p> <p>Subjective/Objective data: Sadness, crying, fear, verbalization of helplessness, hopelessness, lack of appetite</p>	<p><u>Assess</u></p> <p>1.For expressions of sadness, anger, being misunderstood, confusion, depression, disappointment, emptiness, fear, frustration, guilt, or self-blame, helplessness, hopelessness, loneliness, low self-esteem, being overwhelmed</p> <p><u>Prevent</u></p> <p>1.Identify problems with eating or sleeping</p> <p>2.Spend time with the patient and develop a trusting relationship</p> <p>3.Help the patient understand that sorrow may be ongoing; no timetable exists for grieving, despite popular thought</p> <p>4.Evaluate previous coping skills</p> <p>5.Evaluate support systems</p> <div data-bbox="951 971 1291 1075" data-label="Text"> <p>Specify the patient's loss</p> </div> <div data-bbox="968 1187 1257 1344" data-label="Text"> <p>Does the pt have family, friends, government/social services?</p> </div>	<p>1Feelings such as these are indicators of chronic sorrow</p> <p>1.Bereaved individuals have a moderate risk for poor nutrition</p> <p>2.An empathetic person who takes the time to listen, offer support and reassurance, recognizes and focuses on feelings, and appreciates the uniqueness of each individual is helpful to patients experiencing chronic sorrow</p> <p>3.Studies have demonstrated that feelings of sadness, anger, frustration and fear occur periodically throughout the lives of people experiencing chronic loss (this woman is grieving her loss of function and previous lifestyle)</p> <p>4.Helps the nurse understand what has helped the patient in the past and determine whether new coping strategies are needed</p> <p>5.Helps the nurse to understand whether the patient has support or whether additional resources are needed</p>
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	<p>6. Identify available community resources, including grief counselors or support groups</p> <p>7. Identify whether patient is experiencing depression, suicidal ideation, or other emotional disorders. Arrange for counseling services as appropriate</p> <p><u>Evaluate</u></p> <p>1. Patient will express appropriate feelings of guilt, fear, anger, or sadness</p> <p>2. Patient will identify problems associated with sorrow (changes in appetite, insomnia, nightmares, decreased energy)</p> <p>3. Patient will plan for the future one day at a time</p>	<p>6. Support groups can serve as a helpful means to improve interpersonal coping strategies</p> <p>7. Counseling with therapeutic goal setting has been shown to be helpful</p>
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## **Why Such Long Care Plans?**

You are not the first student to ask that question. Much grumbling and complaining goes on in regard to BCC care plans. While you're up late at night all you can think is "This is ridiculous," "They expect too much information," "Why so many details?" "Do I really need to know this?" and so on, and so on, and so on. Welcome to nursing, the BCC way!

I admit to experiencing a wide range of negative feelings about our care plans; I went so far as to wonder if the instructors' primary reason for requiring them to be so detailed and lengthy was to torture us! I'm sure you've had occasion to feel the same way – and if you haven't, you will. Well, let me assure you that these feelings are borne out of sheer frustration (they aren't really trying to torture you). I met many nurses, from several different schools who, upon getting a look at my care plan, gleefully informed me that *theirs* were nothing like *that*. Oh, how I envied them! Now, not so much.

I am convinced that these care plans made me (and will make you) a better nurse. Like you, I often believed that so much of the detailed minutiae that we were required to look up and understand were way above and beyond what we needed to know. Clotting factors? My job is to give the warfarin and monitor prothrombin time; isn't it the physician's job to worry about clotting factors? Beta blockers, calcium channel blockers, ACE inhibitors? They all control high blood pressure, right? Do I really need to know the differences between them? I'm trying to be a nurse, not a pharmacist. Details such as these drove me to heights of frustration and resentment that sometimes made me question whether all this work was worth it. Then, gradually, a strange and wonderful thing began to happen . . . I knew what clotting factors were and which ones were targeted by what medications, without having to look it up. Without a book, I could tell my patient which class of antihypertensive her atenolol was, and how that particular medication works to lower her blood pressure. Inadvertently, almost without my being aware of it, details such as these were incorporated into my knowledge base through the tedium of having to research them over and over while writing care plans. You will research and write about surgeries, medical conditions, laboratory values, and medications so many times you will almost be able to recite them in your sleep. As a result of this, you will eventually come to a place where you are able to synthesize all this information in your head and understand how it all ties together to affect your patient. You are learning to critically think. The exhaustive number of hours you spend on care plans are, minute for minute, hours of invaluable learning. Though you

may be sitting at home, researching and writing, you are undoubtedly growing in your clinical practice.

Let me say that I doubt you will ever enjoy writing a care plan. However, the process will become less challenging and time-consuming as you advance through nursing school. Moreover, you will find yourself on the clinical unit caring for your patients without having to consult your care plan every five minutes. See yourself practicing with confidence . . . that is what your care plans are preparing you to do.

*Section Four. Self Evaluations*

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[illegible]



student alive who hasn't felt that way. Here's my advice: if you have the energy and motivation, think about and write your self eval right away, while the details of clinical are fresh in your mind. However, if being tired might cause you to rush through it, *do not* write your self eval right away. It's really that simple. In your second year, your self-eval is due the morning after your second clinical day, without exception. Putting it off for a few hours rest is not detrimental; you are still completing it before important details have a chance to slip away. In your first year, however, you may have a few days, perhaps even the entire weekend depending on your clinical instructor, before it is due. The same rule applies as to a few hours rest. Do not, however, put it off for more than 24 hours. Waiting longer than that may cause you to forget details about what occurred in clinical, not to mention that attempting to write it at the last minute puts you right where you don't want to be – rushing to get it done. If you absolutely must put it off, do yourself a favor and at least jot down some notes for reference regarding clinical that you want to include. I know it is difficult to believe but you truly can forget things, or not recall them as clearly, as little as one day after clinical. You're tired, you're stressed, you're reading textbooks and handouts, in large volumes, almost constantly. It is very easy for clinical details to get crowded out.

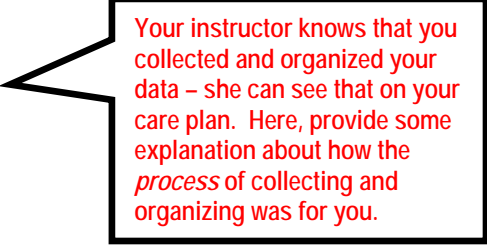

So, rest a bit if you're tired, but get that self eval done as soon as possible.

### **Sample Self Evaluations**

Here I have provided samples of first- and second-year self evaluations. They are intended to illustrate for you the comprehensiveness and degree of detail that is expected. You will notice that the format and content is a bit different for each, but the underlying concept remains the same for both: to evaluate, in writing, your clinical skills.



**BCC**  
Self Evaluation  
NUR 11 & 12

Nurses Roles	Student Comments	Instructor Comments
<b>I. Provider of Care</b>		
a. Data Collection	I am finding that data collection becomes easier each week. As I grow more familiar with the Kardex, med sheets, and the organization of the chart I am able to locate the information I need more quickly and efficiently.	 <p>Your instructor knows that you collected and organized your data – she can see that on your care plan. Here, provide some explanation about how the <i>process</i> of collecting and organizing was for you.</p>
b. Data Organization	I am still struggling to find a way to organize my notes more effectively. My data is well-organized on my care plan, but it seems I am spending a lot of time searching through my notes to access the information I want, which is drawing out the care plan writing process. I am hoping that, with practice, I will be able to better organize my note-taking – thinking ahead to the time when, as a Registered Nurse, my notes will be what I will actually work from as I care for patients.	
c. Planning selected approaches	I planned selected approaches according to my priority diagnosis, which was Risk for Infection. I understood that I would need to observe my patient for any signs of infection related to his surgical procedure and indwelling suprapubic and Foley catheters. In addition, I planned to complete a thorough skin inspection while providing AM care. These approaches were consistent with my identified diagnosis.	 <p>Evaluate how and why you planned care as you did.</p>
d. Implementing	I implemented care as planned, with the exception of performing AM	

care. The patient was scheduled to be discharged, therefore bath and linen change were deferred according to his preference. I had the opportunity to perform some skills I hadn't planned for – such as discontinuing his IV and catheter. It was a little disconcerting, as a student, to be put on the spot this way but provided excellent practice in learning how to adapt to changes in your plan of care.

Were you able to implement care according to your plan? Why or why not? How did you feel about working your plan?

1. Procedures  
(strengths & weaknesses)




I felt more at ease performing the head-to-toe physical assessment. I am growing more confident with this skill each week but realize that there is room for improvement. We have been taught to begin our assessment at the top and work our way down, but I find that I'm still forgetting some things along the way, then having to go back and look at an area that I've already passed. The good thing about this is that I am remembering that I forgot it – in previous weeks I sometimes didn't realize this until filling out the flow sheet. This week, I remembered without needing a reminder.

I think I did well discontinuing the patient's IV and Foley. With the RN's guidance, I gathered all the necessary materials for each procedure and removed the IV, and then the penile catheter. It is quite different to do this on a live person than it is to do in the lab! So as not to make my patient nervous or apprehensive, I acted like I'd done this a hundred times before, which was challenging, to say the least.

I helped the patient dress and prepare for discharge. I spent a lot of time talking with him throughout the course of my shift. I feel I displayed competence in most areas today, not only in caring for my own patient, but in assisting my classmates when needed. I notice that our ability to work as a team seems to be evolving as the weeks progress. We assist and consult one another with confidence, more secure in our clinical knowledge base and practice than we were just

Describe and discuss any procedures you performed. Evaluate your accuracy and comfort level with honesty.

	<p>4 or 5 weeks ago.</p> <p>My biggest weakness is monitoring I&amp;O. I am not as diligent about this as I need to be. I monitor and record the oral intake, but I neglect the intake from IV fluid. In this clinical, I did not record any output. When I D/C'd the patient's Foley, the RN took the bag away to empty it. I forgot to ask her about the volume, and then forgot to check if it had been recorded. In order to improve, I think I'll make I&amp;O a primary focus for next week.</p>	<p>Be willing to admit to weaknesses and mistakes. When you identify a problem area, discuss what you will do in an attempt to improve</p>
2. Physical safety	I was aware of physical safety at all times, both my own and that of my patient.	
3. Biological safety	I wore gloves for all patient contact. I was careful to avoid cross-contamination by changing gloves between D/C of the patient's IV and D/C of his Foley.	<p>Consider your positioning. Did you protect your back? Was the patient's bed in its lowest position with the side rails up? Did you practice standard, contact, and airborne precautions when necessary?</p>
4. Medication Administration/ Calculation	I felt fine about researching, retrieving, and administering my patient's meds. He spoke to me about not wanting to take his iron, because it made him feel sick and unable to eat. I considered his wishes and spoke to his nurse about withholding it, and then did so, indicating such on his med sheet.	
5. Organization of care	I thought care was well-organized. Although my patient did not require close monitoring or a great deal of physical care it was a busy day. Most of us helped a classmate care for their patient in some way when we weren't caring for our own.	
6. Observations	The most important observation I made today was how well we worked as a team. In retrospect, I realized that we each were confident about and focused on our individual tasks but found the time to ask for and give assistance when needed. In comparison to our earlier	<p>Did you feel you were organized? Did you find yourself running around and rushing to get things done? What could you have done differently?</p>

	<p>weeks, gone is the hesitation, fear, and uncertainty about what is required of us and how we are to proceed with patient care. Post-conference also reflects how we've learned and grown, as we are each able to provide a comprehensive yet succinct summary of our patients' conditions and the day's events.</p>	 <div> <p>Include observations about anything you found interesting or were able to learn from</p> </div>
7. Communication skills/IPR		
- Charting	<p>With the exception of I&amp;O, as previously mentioned, I feel fairly confident when charting. I'm sure there is room for improvement, which will come with practice and repetition. Until then, I just ask before charting if I am uncertain about something.</p>	 <div> <p>Was your charting clear, accurate, and comprehensive while remaining concise? How did you feel about charting? How might you improve?</p> </div>
- Reporting	<p>This is growing easier as the weeks go by as well. I am getting to know the nurses on the unit, and vice versa, and am developing a routine for consulting with the RN prior to care, and providing updates throughout the shift as necessary. They are good about providing us with information as well, particularly about procedures we may want to take part in.</p>	 <div> <p>Did you feel comfortable about differentiating between what you need/don't need to report? Was your nurse receptive? Cooperative?</p> </div>
- Teaching	<p>I taught my patient how, before standing, he needs to sit up on the edge of his bed for a few minutes in order to avoid becoming dizzy or lightheaded. I provided an explanation, and then had him demonstrate.</p>	
- Evaluating	<p>I was able to evaluate my patient's understanding by observing his ability to follow my directions. He was successful at assimilating knowledge regarding the content of my teaching.</p>	
<b>II. Manager of Care</b>		
Seeks assistance from appropriate health members	At this point in clinical, I am seeking out my clinical instructor or	

primary nurse for assistance when needed and have not progressed to consulting members of other disciplines.

### III. Member of Profession

- a. Agency Resource Manuals      Although I know their location, I did not need to consult resource manuals this week
- b. Agency Policies & Procedures      I was aware of the procedures to follow for care that I provided. I understand that I need to consult with the policy and procedure binders if at all uncertain about the hospital's protocols.
- c. Self Evaluation      I believe my self evaluation to be honest, comprehensive and specific to this week's experience.

### IV. Program Requirements

- a. Attendance      Perfect attendance to date
- b. Assignments      All assignments complete and submitted on time
- c. Math Exam      Passed on first attempt with 95%
- d. Participation in pre- and post-conference      I believe my participation is satisfactory and that I am prepared to discuss and share any information pertaining to my patient assignment
- e. Appearance      I am in uniform, which is clean and pressed, as required.
- f. Behavior      Appropriate and consistent.
- g. Veracity      Beyond reproach, as is expected

As a member of the profession, do you feel you are literate in the community of nursing? Do you understand how to find and utilize resources, such as policy, procedure, and protocol manuals? Do you feel that any knowledge you obtained from the manuals helped you grow as a member of the nursing profession?

Evaluate your self-evaluation

**NUR 51 & 52 SELF EVALUATION**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please address the following areas plus any others you wish or need to comment on. Use End-Of-Course Behaviors as guide. Add paper PRN.

**COMMENTS**

**PROVIDER** (data collection, NCP, worksheet, organization, assessment, skills, revisions)

I am mostly satisfied with my performance in these areas this week. I was able to gather all pertinent information on my patient and organize it effectively. I really felt like I understood this patient, what her needs were, and what I needed to do to care for her. I felt really comfortable about reprioritizing after interacting with her the first day. This has been one of my best clinical weeks as far as my growth and development as a nurse. I felt like I was able to take in and synthesize new information based on my assessments without having to dig in a book to know what to do. My care plan (finally!) felt more like a useful tool rather than a burden. I believe it was detailed and thorough, and my revisions appropriate, and provided me with a useful framework from which to provide care. I am becoming less attached to my worksheet, as well. Although I take it out occasionally, for reminders or to jot down new information, I am less dependent on it. I am aware of cognitive growth taking place, as I am able to keep information about my patient in my head, as well as assimilate new findings, and analyze how things all tie together.

My assessments are careful and thorough. As a student, I am always afraid of the possibility of missing something (and probably will continue to be as a nurse). For example, I worried after the first clinical day that I had not been able to look at my patient's IV access site due to the bandaging that covered it. By day 2, when I could see that the bandage had not been changed, I grew very concerned about the fact that no one had looked at her access site for at least 24 hours. After first getting permission, I removed the bandaging and was able to inspect the area and determine that the site was normal and the IV patent, much to my relief. My philosophy is that you can never be too careful.

As to skills, I was able to learn and do some new things such as hanging an IV bag and setting the pump and removing an NG tube. I was definitely nervous, but tried my best to hide that from the patient. I need more practice and improvement with these skills, naturally, but now that I've done them at least once they are not so intimidating.

**COMMUNICATOR** (clarity, accuracy, use of therapeutic interactive techniques with pts., staff, charting)

I believe I am an effective communicator. I love talking with my

How was data collection? Did you encounter any difficulties? How do you feel about your care plan? Did you struggle with it and, if so, how and why? How did you feel about working from your worksheet? Do you prefer working directly from your care plan?

Be specific about assessments or skills that you are discussing



patients and thus far have not had difficulty establishing trusting relationships with them. I always listen carefully to what they tell me and try to adjust my therapeutic interactive techniques to their individual needs.

Communication with staff was clear, beneficial, and bidirectional. I learned some things about clarity and accuracy on the flow sheet with the help of my primary nurse. She taught me how to chart procedures/treatments (like discontinuing the NG tube) and how to put an asterisk by the notation on the flow sheet to indicate that I had written a nursing note about it.

**TEACHER** (assess need, provide explanation and demo)

I talked with my patient about the importance of turning and repositioning frequently in order to prevent infection and skin breakdown. Although I assured her that I would check on her often (because of her diarrhea), I told her that it was important for her to use the call button if she moved her bowels while I wasn't there, so that her skin would not become irritated. I also demonstrated coughing and deep breathing, but was met with considerable resistance, which I feel was due to her inability to focus secondary to her nausea and discomfort.

**MANAGER** (prioritizing for 2 clients, delegating, interacting with health team members)

I had only a one patient assignment this week, and so did not need to prioritize, nor did I delegate any care. I did approach my primary nurse about the possibility/feasibility of getting the patient out of bed and we collaborated about initiating a PT consult. Ultimately, we discovered that the MD had already ordered a PT evaluation. Nonetheless, I'm gratified that we were thinking along the same lines, and had a discussion about how to best approach this aspect of the patient's care.

**MEMBER** (legal-ethical practice; ID own strengths/areas to develop; seek learning opportunities)

I believe myself to be a conscientious provider of care, respectful of, and in compliance with legal and ethical guidelines. My strength this week was my ability to soothe my patient and communicate unconditional positive regard. She was distressed (and likely embarrassed) about her excessive diarrhea. I was able to help her relax and assured her that it was okay if she made a mess, that I would be right there to keep her clean and comfortable. In fact, I encouraged her to just let it come and not try to hold it back (not that she could).

You are always a teacher! Don't ever leave this blank or say that you didn't teach anything. Even if the patient wasn't receptive, describe what, and how, you attempted to teach

Even if you do not have more than one patient, discuss how you managed care on your own, or with other health team members

Try to be specific about what your strengths and weaknesses were this particular clinical week. As a member of the profession, do you feel you are improving in your own practice and/or improving nursing as a whole?

<p>This may not seem like a big deal to an ordinary (non-nursing) person, but as I leaned over her, held her hand, and looked into her eyes as I spoke, I could see her relief as her anxiety melted away.</p> <p>I need to work on consolidating my care. I tend to pace myself so that I don't end up being bored and feeling useless. I really need to develop in this area because I understand that, as a nurse with several patients, I will not have the luxury of doing this. I am confident that I will get plenty of practice as my patient assignment grows with the progression of the semester.</p> <p>I am always eager to observe or participate in new learning opportunities. This week I got to watch one of my classmates use sterile technique and change a complicated dressing.</p> <p><b><u>PROGRAM REQUIREMENTS</u></b> (punctuality, prep and participation in conference)</p> <p>I believe my performance in these areas was satisfactory. I feel that pre-conference provided an excellent foundation before meeting the patient, and post was a valuable forum for evaluation of the day's objectives.</p>	
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## AFTERWORD

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It is my sincere hope that this manual was helpful in guiding you through the care planning and self evaluation process. It is important that you know that these writing endeavors are only the beginning of what will be required of you in the nursing program. The writing assignments will grow more complex as you progress through each semester, requiring a higher level of thinking, organization, and expression. Learning, early on, how to write effectively will provide a solid foundation for the challenges to come.

I encourage you to take advantage of the services provided through the college's Writing Lab. Their excellent staff, comprised of faculty members and peer tutors, can help you navigate your way through any phase of the writing process. In addition, you will find writing samples, specific to the nursing program, that you may use as models to assist you in successfully completing your own writing assignments.

If, after reading this manual, you believe that I am an effective writer and successful student, then I thank you. However, I ask you to remember that much of my success would not have been possible without some help along the way. I have not only had the privilege of working as tutor, but have had the benefit of being tutored as well, and that has made all the difference. There have been tutors at this college who helped turn what was simply good work into my best work. I encourage you to take full advantage of this college's many resources – particularly tutoring – and watch yourself grow, and become the most successful student you can be.

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## Appendix A

### Basic Human Needs and Related Nursing Diagnoses

#### 1. Oxygenation

- Ineffective airway clearance
- Impaired gas exchange
- Ineffective breathing pattern
- Ineffective tissue perfusion (specify peripheral, cardiopulmonary, GI, renal, or cerebral)
- Decreased cardiac output

#### 2. Hydration

- Deficient fluid volume
- Fluid volume excess
- Risk for imbalanced fluid volume

#### 3. Nutrition

- Impaired swallowing
- Self-care deficit, feeding
- Imbalanced nutrition (specify less than or more than body requirements)
- Impaired oral mucous membranes
- Nausea

#### 4. Involuntary Regulation

- Delayed growth and development
- Hyperthermia
- Hypothermia
- Ineffective thermoregulation
- Adult failure to thrive

#### 5. Elimination

- Impaired urinary elimination
- Urinary incontinence (specify functional, reflex, stress, total, or urge)
- Urinary retention
- Constipation
- Diarrhea
- Bowel incontinence
- Self-care deficit, toileting

## **6. Safety/Security**

- Impaired tissue integrity
- Impaired skin integrity
- Risk for impaired skin integrity
- Risk for infection
- Ineffective protection
- Risk for falls
- Risk for injury

## **7. Comfort**

- Acute pain
- Chronic pain
- Fear
- Anxiety
- Chronic sorrow
- Disturbed sleep pattern
- Ineffective coping

## **8. Activity**

- Activity intolerance
- Impaired transfer ability
- Impaired physical mobility
- Impaired bed mobility
- Deficient diversional activity

## **9. Communication**

- Impaired verbal communication
- Readiness for enhanced communication

## **10. Sensation**

- Disturbed sensory perception (specify visual, auditory, kinesthetic, gustatory, tactile, olfactory)
- Acute confusion
- Chronic confusion

## **11. Self-esteem**

- Disturbed body image
- Ineffective coping
- Disabled family coping
- Hopelessness

Powerlessness  
Noncompliance  
Situational low self-esteem  
Chronic low self-esteem  
Deficient knowledge  
Sexual dysfunction  
Social isolation

**12. Independence**

Ineffective health maintenance  
Deficient knowledge  
Health-seeking behaviors

**13. Hygiene**

Self-care deficit, bathing/hygiene  
Self-care deficit, dressing/grooming  
Impaired skin integrity  
Impaired oral mucous membranes









