Instructor: _____

Course: _____

Santa Monica College
Nursing Care Plan
Plan for Promotion of Self Care

Student Name:_____

Date: _____

Hospital: _____

Patient's Initials: _____ Age: _____ Gender: _____ Allergies: _____ Room/Bed# _____

Dm.Dx./Date:_____ Surgical procedure/Date: _____

Health Deviation

History of Present Illness	Concurrent/past medical history(hospitalizations,surgeries)

Current Significant Lab Findings/Diagnostic Test (Date)				
Name	Lab	Norm	Rationale	Other
WBC				
RBC				
HGB				
HCT				
BUN				
Creatinine				
Na+				
K+				
CI				
CO2				
Protein				
Glucose				
Bilirubin				
Ketones				

Treatments	Medications / Classification / Expected Outcomes

Nursing Diagnosis (Include TSCD)	Outcome / Goal	Nursing System / Nursing Orders	Evaluation
(TSCD)	**Pt. will:**		
NS Dx:			
R/t:			
MB:			
(TSCD)	**Pt. will:**		
NS Dx:			
R/t:			
MB:			

USCR: Air ⇨ Water ⇨ Food ⇨ Elimination ⇨ Activity/Rest ⇨ Solitude/Social Interaction ⇨ Protection from Hazard ⇨ A Sense of Normalcy

Santa Monica College Nursing Program
Assessment – Data Collection

AIR

Subjective Data – Patient Interview

1. Do you have:

❑ Difficult breathing _____
❑ Dizziness _____
❑ Wheezing _____
❑ Coughing _____

2. Has there been a recent change in your ability to breathe? ❑ No ❑ Yes _____

_____
_____

3. Have you ever smoked?

❑ No ❑ Yes (Amount/day_____)
Year Started _____ Year Stopped_____

4. Comments: _____

Objective Data – Nursing Assessment

Respiration: Rate_____

❑ WNL ❑ Irregular ❑ Labored
❑ Shallow ❑ Deep ❑ Other

Breath Sounds:	**R**	**L**		**R**	**L**
Clear	❑	❑	Diminished	❑	❑
Crackles	❑	❑	Stridor	❑	❑
Wheezes	❑	❑			

Artificial Airway:

❑ No ❑ Yes
Type _____ Size _____

Actual/Risk for Nursing DX

- ❖ Ineffective airway clearance
- ❖ Ineffective breathing pattern
- ❖ Impaired gas exchange
- ❖ Risk for aspiration
- ❖ Ineffective tissue perfusion

FLUIDS

Subjective Data – Patient Interview

1. Have you ever been told to limit or increase your fluid intake?

❑ No ❑ Yes (Amount/day_____)

2. Comments: _____

_____
_____
_____
_____
_____
_____

Objective Data – Nursing Assessment

Skin Turgor: ❑ Good ❑ Poor
Edema: ❑ No ❑ Yes **Mucous Membranes:** ❑ Dry ❑ Moist
B.P. _____ **Heart Rate** _____

	Radial		Apical	Dorsalis Pedis		Post Tibialis	
Pulse Quality	**R**	**L**		**R**	**L**	**R**	**L**
Reg/Irregular							
Full							
Weak							
Absent							
Non-Palp/Dop.							

Actual/Risk for Nursing DX

- ❖ Fluid volume deficit
- ❖ Fluid volume excess
- ❖ Ineffective tissue perfusion: peripheral

FOOD

Subjective Data – Patient Interview

1. What is your usual diet?

❑ Regular ❑ Special

2. Do you have any special problem with:

❑ Feeding self _____
❑ Chewing _____
❑ Swallowing _____
❑ Pain _____
❑ Heartburn _____
❑ Vomiting _____

One Day Sample Diet

B. _____
L. _____
D. _____
Snack _____

3. Do you have any tube/catheter/IV used for feedings or medication?

❑ No ❑ Yes _____

_____

4. Have you had any changes in diet due or illness?

❑ No ❑ Yes _____

_____

5. Have you had any recent weight gain/loss?

❑ No ❑ Yes _____

_____

6. Do you have dentures? ❑ No ❑ Yes
❑ Upper: Full/partial ❑ Lower: Full/Partial

7. Do you have any food allergies?

❑ No ❑ Yes _____

_____

Objective Data – Nursing Assessment

Tube / Catheter / IV:

Type _____ **Site** _____

_____

Overall physical appearance:

❑ Normal ❑ Cachetic ❑ Obese

Weight : (lb. x 2.2) = _____kg
Height : (in. x 2.54) = _____cm

Dentures brought to hospital?

❑ No ❑ Yes
❑ Upper: Full/partial ❑ Lower: Full/Partial

Comments: _____

_____
_____
_____
_____

Actual/Risk for Nursing DX

- ❖ Impaired dentition
- ❖ Imbalanced nutrition: less than body requirements
- ❖ Risk for imbalanced nutrition: more than body requirements
- ❖ Self-care deficit
- ❖ Impaired mucous membranes
- ❖ Impaired swallowing

		Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
ELIMINATION	**Bowel**	***1. How often do you have a bowel movement?*** _____ Color_____Consistency _____ ***2. Do you do anything to regulate your bowels?*** ❑ No ❑ Yes ❑ Medications_____ ❑ Enemas _____ ❑ Juices _____ ❑ Foods _____ ***3. Since your illness do you have:*** ❑ Constipation? _____ ❑ Diarrhea? _____ ❑ Discharge? _____ ❑ Other _____ ❑ No problem ***4. When you move your bowels, do you have:*** ❑ Pain/Cramping? _____ ❑ Discharge? _____ ❑ Bleeding? _____ ***5. Do you have any urinary tubes/ drains/ostomies?*** ❑ No ❑ Yes_____ _____ ***6. Do you have hemorrhoids?*** ❑ No ❑ Yes_____ _____ ***7. Other:*** _____ _____	**Bowel Sounds:** ❑ Present _____ ❑ Absent _____ **Abdominal Distention:** ❑ No ❑ Yes _____ **Abdominal Girth:** _____ _____ **Tubes/Drains/Ostomies:** ❑ No ❑ Yes Type_____ Site _____ **Incontinence:** ❑ No ❑ Yes _____ _____ **Comments:** _____ _____ _____ _____ _____	❖ Bowel incontinence ❖ Diarrhea ❖ Constipation ❖ Risk for constipation
	Bladder	***1. How often do you urinate?*** _____ Color _____ Amount_____ ***2. When you urinate do you have:*** ❑ Pain?_____ ❑ Burning?_____ ❑ Discharge? _____ ❑ Bleeding? _____ ❑ Other _____ _____ ***3. Since your illness, do you urinate:*** ❑ More frequently? _____ ❑ Less frequently? _____ ❑ At night? _____ ❑ Accidentally? _____ ❑ Other?_____ ***4. Do you have any urinary tubes/ drains/ostomies?*** ❑ No ❑ Yes ***5. Other:*** _____	**Bladder Distention :** ❑ No ❑ Yes_____ _____ **Hesitancy** _____ **Frequency** _____ **Dribbling**_____ **Incontinence** _____ **Tubes/Drains/Ostomies:** ❑ No ❑ Yes Type_____ Site _____	❖ Impaired urinary elimination ❖ Ineffective perfusion: renal ❖ Self-care deficit: toileting
ACTIVITY – REST	**Activity**	***1. Do you have any physical limitations?*** ❑ No ❑ Yes_____ _____ _____ ***2. Do you have any changes in activity due to illness?*** ❑ No ❑ Yes_____ _____ _____ ***3. Do you use devices/prosthetics for activity?*** ❑ No ❑ Yes _____ _____ _____ ***4. Do you exercise?*** ❑ No ❑ Yes How often _____ Type_____ _____ _____	**Motor Limitations?** ❑ No ❑ Yes _____ _____ **Gait Disturbances:** ❑ No ❑ Yes _____ _____ **Devices/Prosthetics brought to hospital?** ❑ No ❑ Yes _____ _____ _____	❖ Activity intolerance ❖ Deficient diversional activity ❖ Impaired home maintenance ❖ Impaired physical mobility ❖ Risk for disuse syndrome
	Rest	***1. How many hours do you usually sleep?*** When? _____ Naps? _____ ***2. Do you use anything to help you sleep?*** ❑ No ❑ Yes_____ ❑ Medication _____ ❑ Food _____ ❑ Activity _____ ***3. Do you have any changes in sleep patterns due to illness ?*** ❑ No ❑ Yes ***4. How many pillows do you usually use ?*** _____ ***5. Other:*** _____	**Comments:** _____ _____ _____ _____ _____ _____	❖ Disturbed sleep pattern ❖ Fatigue ❖ Sleep deprivation

		Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
SOCIAL INTERACTIONS	Level of Consciousness	***1. Do you have any recent changes in your thinking or memory?*** _____ ❑ No ❑ Yes_____ ***2. Other:*** _____	**Level of consciousness:** ❑ Alert ❑ Lethargy ❑ Stupor ❑ Comatose Oriented to: Person / Place / Time / Event — NO / YES Comments _____	❖ Disturbed thought process ❖ Acute confusion ❖ Chronic confusion ❖ Impaired Memory ❖ Unilateral neglect
	Memory Barriers	***1. Do you have any problems with:*** ❑ Vision_____ ❑ Hearing _____ ❑ Speech_____ ❑ Other: _____ ***2. Do you use:*** ❑ Glasses _____ ❑ Contact lenses _____ ❑ Hearing aids _____ ❑ Speech devices_____ ❑ Other prostheses _____ ***3. Other:*** _____	**Brought to hospital:** ❑ Glasses _____ ❑ Contact lenses_____ ❑ Hearing aid(s) _____ ❑ Speech devices _____ ❑ Other prostheses _____ Comments _____	❖ Disturbed sensory perception: Visual, auditory, olfactory ❖ Impaired verbal communication ❖ Impaired communication
	Language Barriers	***1. What do you prefer we call you?*** _____ ***2. What is your primary language?*** _____ ***3. What other languages do you speak?*** _____ ***4. Family/friends available to translate?*** ❑ No ❑ Yes Name _____ Phone_____ Name _____ Phone_____	**Able to communicate in English:** ❑ Fluently ❑ Some ability ❑ Not at all Comments _____	❖ Impaired social interaction ❖ Risk for loneliness ❖ Ineffective individual coping
	Support Systems	***1. Whom do you rely on for emotional support?*** _____ ***2. Will they be nearby while you are in the hospital?*** ❑ No ❑ Yes_____ ***3. Do you have any concerns about your home situation while you are hospitalized?*** ❑ No ❑ Yes _____ ***4. What is your religious preference?*** _____ ***5. Do you have any special cultural/spiritual practices you would like to observe while you are here?*** ❑ No ❑ Yes _____ ***6. Other:*** _____	**Potential referrals for clients/family during hospitalization:** ❑ Clinical Nurse Specialist ❑ Social Worker ❑ Dietician ❑ Physical Therapy ❑ Clergy ❑ Financial Counseling ❑ Patient Liason ❑ Other _____ ❑ None of the above Reason for referral(s): _____	❖ Interrupted family process ❖ Impaired parenting ❖ Disabled family coping ❖ Spiritual distress ❖ Grieving ❖ Social isolation ❖ Risk for loneliness
SAFETY/COMFORT	Pain	***1. Do you have any pain associated with your illness?*** ❑ No ❑ Yes ***2. Do you use anything to relieve your pain?*** ❑ No ❑ Yes ***3. Do you have any pain now ?*** ❑ No ❑ Yes Where? _____ When?_____ How much? _____ What helps?_____ What makes it worse? _____ ***4. Other:***	**Complete section if patient currently in pain:** GENERAL FACIAL EXPRESSION: ❑ Calm ❑ Grimacing ❑ Anxious ❑ Crying BODY POSITION: ❑ Sitting/lying comfortably ❑ Restless _____ ❑ Splinting _____ ❑ Other _____ Comments:_____	❖ Acute pain ❖ Chronic pain

DEVELOPMENTAL – NORMALCY / SAFETY / COMFORT

Protection from Hazards

Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
1. Do you require assistance with? ❑ Walking_____ ❑ Turning in bed_____ ❑ Other _____ ❑ None of the above_____ ***2. Do you become confused or disoriented under any circumstances?*** ❑ No ❑ Yes _____ ***3. Other:*** _____	**Comments:** _____	❖ Wandering ❖ Risk for injury ❖ Risk for falls

Infection Control

Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
1. Do you have any infections or communicable disease? ❑ No ❑ Yes _____ ***2. Have you been exposed to any communicable disease recently?*** ❑ No ❑ Yes _____ ***3. Have you been told to take precautions to protect yourself or others?*** ❑ No ❑ Yes What precautions? _____ When/how often?_____ Are you doing this? _____	**Temperature:** **C °** **F °** **Signs/symptoms of communicable diseases or infections?** ❑ No ❑ Yes_____ **Comments:** _____	❖ Hyperthermia ❖ Hypothermia

Skin

Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
1. Do you have any of the following skin problems? ❑ Rash _____ ❑ Itching_____ ❑ Bruises _____ ❑ Cuts_____ ❑ Redness/swelling_____ ❑ Ulcers/sores _____ ❑ Other _____ ❑ None of the above ***2. Do you bruise or bleed easily?*** ❑ No ❑ Yes ***3. Other*** _____	**Skin color:** ❑ Normal ❑ Pale ❑ Cyanotic ❑ Red/flushed ❑ Jaundiced ❑ Other **Risk factors for skin breakdown:** ❑ Immobile ❑ Incontinent ❑ Obese ❑ Malnourished ❑ Diabetic ❑ PVD ❑ Elderly ❑ None of the above Description of altered skin integrity_____	❖ Impaired skin integrity ❖ Impaired tissue integrity ❖ Risk for impaired skin integrity

Personal Comfort

Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
1. What is your usual: Bathing patterns _____ Oral care patterns _____ ***2. Other*** _____	**Observations regarding hygiene:** _____	❖ Self-care deficit: bathing/hygiene ❖ Self-care deficit: dressing/ grooming

Stress

Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
1. How do you usually react to stressful situations? ❑ Avoidance _____ ❑ Develop physical symptoms_____ ❑ Talk to others _____ ❑ Keep feelings to self _____ ❑ Sleep/withdraw _____ ❑ Smoke _____ ❑ Use alcohol _____ ❑ Use medication_____ ❑ Use drugs_____ ❑ Change eating habits_____ ❑ Use exercise/physical activity_____ ❑ Rely on religion _____ ❑ Gather info & plan _____ ❑ Other _____ ***2. Do you have any special concerns related to your hospitalization?*** ❑ No ❑ Yes _____ ***3. Other:*** _____	**Behavioral observations:** _____ **Comments:** _____	❖ Ineffective health maintenance ❖ Ineffective individual coping ❖ Anxiety ❖ Fear ❖ Actual/risk for other directed violence ❖ Self mutilation ❖ Decisional conflict

DEVELOPMENTAL – NORMALCY

	Subjective Data – Patient Interview	Objective Data – Nursing Assessment	Actual/Risk for Nursing DX
Body Image	***1. Do you have any changes in your abilities/appearance that affects how you feel about yourself?*** ❑ No ❑ Yes _____ _____ ***2. Other:*** _____ _____ _____ _____	**Comments:** _____ _____ _____ _____ _____	❖ Disturbed body image ❖ Situational low self-esteem
Sexual/Reproduction	***1. Has there been a change in sexual activity?*** ❑ No ❑ Yes _____ _____ ***2. Do you anticipate a change?*** ❑ No ❑ Yes _____ _____ ***3. If female, answer the following:*** a. When was your last menstrual period? _____ b. Are you using birth control methods? ❑ No ❑ Yes _____ ***4. Have you had any problems with vaginal/penile discharge or infections?*** ❑ No ❑ Yes _____	**Comments:** _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	❖ Sexual dysfunction ❖ Ineffective sexuality patterns
Social-economic	***1. What is your usual occupation/profession?*** _____ _____ ***2. Are you employed currently?*** ❑ No ❑ Yes _____ ***3. What is your cultural/ethnic background?*** _____ _____ ***4. What do you enjoy doing in your leisure time?*** _____ _____	**Comments:** _____ _____ _____ _____ _____ _____ _____ _____	❖ Disturbed personal identity ❖ Anxiety ❖ Powerlessness ❖ Ineffective role performance

Teaching / Discharge Planning

1. What do you know about your illness/treatment? _____ _____ ***2. What further information do you want?*** _____ _____ ***3. Do you have any specific questions at this time?*** _____ _____ ***4. How long do you expect to be in the hospital?*** _____ _____	***5. When you leave the hospital, where will you go?*** _____ ***6. Will someone be there for you?*** ❑ No ❑ Yes _____ ***7. Do you think you will need any additional help or equipment at home?*** ❑ No ❑ Yes _____ ***8. Do you have any other concerns related to leaving the hospital?*** ❑ No ❑ Yes _____ ***9. What do you know about your medication?*** _____ _____	**Teaching needs identified:** _____ _____ _____ _____ _____ _____ **❑ Estimated maximum stay (from referral sheet):** _____ **❑ Potential referrals for discharge (specify reason):** _____ **❑ Clinical Nurse Specialist** _____ **❑ Social Worker** _____ **❑ Home Health Agency** _____ **❑ Community Agency** _____ **❑ Other** _____ **❑ Clinical Nurse Specialist** _____	❖ Deficient knowledge ❖ Social isolation ❖ Anxiety ❖ Ineffective role performance ❖ Health seeking behaviors

Nursing Student Signature _____ **Date** _____ **20**_____