



# NURSING CARE PLANS

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# Nursing Care Plan

- Known to be the “blueprint” of the nursing process
- Used to identify the scope and depth of the nursing practice
- Evidenced by:
  - Sufficient data collection
  - At least one goal stated per nursing diagnosis
  - Outcome criteria identified for each goal
  - Nursing interventions related to the nursing diagnosis
  - Nursing Rationales supported by scientific data
  - Evaluation of each nursing goal

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# Assessment

- Systematic collection, verification, organization, interpretation and documentation of data.
- Focuses on the client's response to health problems, perceived health needs and health practices and values
- Goal is the collection and analysis of data that are used in formulating nursing diagnoses, identifying outcomes and developing nursing interventions.

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# Types of Data

- Subjective Data

- Data from the client's point of view and includes feelings, perceptions and concerns
- Rely on the feelings or opinions of the person experiencing them
- Obtained through interviews with the client

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# Types of Data

- Objective Data
  - Observable and measurable
  - Data that are obtained through observation, standard assessment techniques performed during a physical examination, laboratory and diagnostic testing
  - Signs felt other than the person experiencing them

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# Example

- Pt G.A., age 45 went to the hospital due to complains of passing out in the middle of the street for the past 2 days. She tells the nurses that she felt lightheadedness after any form of activity. She has experienced nausea and vomiting after eating breakfast and lunch this morning. She said her father had the same symptoms before and she feels nervous about her situation. The nurse observes that the client's skin is pale and her gait is unsteady. There is also a large bruise on her left arm and right face which occurred when she once fell. Her blood pressure is 90/60 mmHg, Pulse rate 91 bpm, Respiratory Rate 18 rpm.

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# Answer

- Subjective
  - Report of fainting
  - Complains of dizziness
  - Nausea
  - Verbalization of anxiety
  - Self reported fall
- Objective
  - Vomiting
  - Unsteady gait
  - Pale skin
  - Bruises on right side of face and right arm
  - BP = 90/60 mm Hg
  - PR = 91 bpm
  - RR = 18 rpm

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# Diagnosis

- Results to a diagnostic statement of nursing diagnosis
- Clinical act of identifying problems
- To analyze assessment information and derive meaning from this analysis

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# Nursing Diagnosis

- A statement of a client's potential or actual alteration of health status
- Uses critical thinking skills of analysis and synthesis
- Format:
  - PRS : Problem, Related Factors, Signs and Symptoms
  - PES: Problem, Etiology, Signs and Symptoms

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# Examples

- Anxiety related to insufficient knowledge regarding a surgical experience
- Ineffective Airway clearance related to tracheobronchial infection as manifested by weak cough, adventitious breath sounds and green sputum production
- Risk for injury related to sensory and integrative dysfunction as manifested by altered mobility and faulty judgement

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# Comparison of Correct and Incorrect Nursing Diagnosis

- High risk for ineffective Airway clearance related to thick secretions
- High risk for ineffective Airway clearance related to pneumonia
- High risk for injury related to absence of side rails
- High risk for injury related to disorientation
- Mastectomy related to Cancer
- High risk for self-concept disturbance related to the effects of mastectomy

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# Steps of Data Analysis

- Recognize the pattern or trend
  - 20 pound weight loss
  - Poor appetite
  - Weakness
  - Previous falls
- Compare the standards for normal
  - No weight loss
  - Adequate nutritional intake
  - No history of falls
- Make a reasonable conclusion
  - Mobility and Stability problems
  - Inadequate nutritional intake

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# Types of Nursing Diagnosis

## ■ Actual

- Describes human responses to health conditions that exist in an individual, family or community

## ■ Risk

- Describes human responses that may develop in a vulnerable individual, family, community

## ■ Wellness

- Describes human responses to levels of wellness in an individual, family, or community that have a readiness for enhancement

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# Formulation of Nursing Diagnosis

- Problem — identifies what is unhealthy about patient
- Etiology — identifies factors maintaining the unhealthy state
- Defining characteristics — identifies the subjective and objective data that signal the existence of a problem

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# Components of a Nursing Diagnosis

- Diagnostic level
  - Name of the nursing diagnosis as approved by NANDA
- Related Factors/Etiology/Definition/Risk factors
  - Causative or other contributory factors that have influenced the client's actual or potential response to health conditions
  - Cause of the nursing diagnosis
  - Describes the characteristics of the human response identified
  - May be environmental, physiological, psychological that increases the vulnerability of the individual
- Support label
  - Nursing assessment data that supports the nursing diagnosis

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# Planning

- Directs activities to be carried out in the implementation phase
- Involves priority setting which helps the nurse attend to the client's most important needs and assists the nurse in organizing ongoing care activities.

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# Goals of Care: Client centered goal

- Goals should be realistic and based on the client's needs and resources
  - Short term
    - achieved in a shorter time frame usually less than a week
  - Long term
    - achieved in a longer time frame usually more than a week or over months

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# Implementation

- Step in the nursing process where nurses provide care for the clients
- the start of the nursing actions to achieve the goals and expected outcomes of the nursing care.
- Direct care
  - Through an interaction with a client
- Indirect care
  - No interaction with a client

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# Types of Nursing Interventions

- Independent nursing actions
  - Nurse-initiated interventions
    - Protocols
    - Standing orders
- Dependent and collaborative nursing actions
  - Physician-initiated interventions
  - Collaborative interventions

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# Evaluation

- Determines the usefulness and effectiveness of the nursing practice and nursing care rendered
- The nurse decides whether the previous steps of the nursing process were effective by examining the client's responses

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# Four Types of Outcomes

- Cognitive — increase in patient knowledge
- Psychomotor — patient's achievement of new skills
- Affective — changes in patient values belief, and attitudes
- Physiologic — physical changes in the patient

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# Evaluating Outcomes

- Cognitive — asking patient to repeat information or apply new knowledge
- Psychomotor — asking patient to demonstrate new skill
- Affective — observing patient behavior and conversation
- Physiologic — using physical assessment skill to collect and compare data

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# Variables Affecting Outcome Achievement

- Patient
  - E.g., a patient gives up and refuses treatment
- Nurse
  - E.g., a nurse is suffering from burn-out
- Healthcare system
  - E.g., inadequate staffing

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# Evaluative Statements

- Decide how well outcome was met (met, partially met, or not met)
- List patient data or behaviors that support this decision

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# Revisions in the Plan of Care

- Delete or modify the nursing diagnosis.
- Make the outcome statement more realistic.
- Adjust time criteria in outcome statement.
- Change nursing interventions.

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# Questions to Insure a Firm Commitment to Evaluation

- What are the patient's outcomes?
- What are nursing's values?
- How can these values be formalized in standards and evaluative criteria?
- What data exist to determine whether criteria are met?
- How can these data best be collected, analyzed, and interpreted?
- To what courses of actions do the findings

lead?

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**Example: Patient H.K. is diagnosed with lung cancer. He was admitted 3 days ago. Assessment data shows:**

- Diarrhea for 2 weeks
- Distended Abdomen
- 10 pack year history of smoking
- Family history of stomach cancer
- Weight upon admission 61 kg
- Weight loss 10 kg since admission
- Productive cough upon rising each morning
- Crackles auscultated on both lung fields
- Anxiety
- Ribbon like stools
- Cramping before and after each bowel movement
- Talkative
- Frequently asks questions about cancer
- Attends church weekly
- With good attention span
- Previous history of falls

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# Assessment:

- Subjective Data
  - ❑ Previous history of falls
  - ❑ Experienced diarrhea for 2 weeks
  - ❑ 10 pack year history of smoking
  - ❑ Confirms a family history of stomach cancer
  - ❑ Reports he attends church weekly
  - ❑ Poor appetite
- Objective Data
  - ❑ Productive cough upon rising each morning
  - ❑ Crackles auscultated on both lung fields
  - ❑ Ribbon like stools
  - ❑ Cramping before and after each bowel movement
  - ❑ Talkative
  - ❑ Frequently asks questions about cancer
  - ❑ With good attention span
  - ❑ Distended Abdomen
  - ❑ Weight loss 10 kg since admission
  - ❑ Weight upon admission 61 kg
  - ❑ Consumes 25% of food served

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# Steps of Data Analysis

- Recognize the pattern or trend
  - 20 pound weight loss
  - Poor appetite
  - Weakness
  - Previous falls
  - Consumes 25% of food served
  - Experienced diarrhea for 2 weeks
  - Ribbon like stools
  - Distended Abdomen
- Compare the standards for normal
  - No weight loss
  - Adequate nutritional intake
  - No history of falls
  - Semi-formed, golden brown stool
  - Globular, scaphoid abdomen
- Make a reasonable conclusion
  - Mobility and Stability problems
  - Inadequate nutritional intake
  - Alteration of elimination patterns

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# Diagnosing

- Activity intolerance
- Altered nutrition: less than body requirements related to inability to absorb nutrients because of chronic diarrhea for 2 weeks
- Diarrhea
- Fluid volume deficit

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# Planning

- Short term

- After \_\_\_\_\_ of medical and nursing intervention, the patient will be able to \_\_\_\_\_ as manifested by \_\_\_\_\_

- Long term

- After \_\_\_\_\_ of medical and nursing intervention, the patient will be able to \_\_\_\_\_ as manifested by \_\_\_\_\_

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# Implementation

- Diagnostics
- Therapeutics
- Educative

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# Evaluation

- Goal met
- Goal not met
- Goal partially met



END OF SESSION

Thank you