

# **Our Experience with Nursing Care Plan: A Journey since 1990's**

## **American University of Beirut Medical Center Nursing Services**



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# Nursing Care Plan At AUBMC

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**Nursing Care Plan has always been considered as essential component in the daily care of AUBMC staff nurses since decades**

# The good old days

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- ✿ Until late 1990's, staff nurses used to document the care plan on the cardex.
- ✿ Care plan was fully documented with selected diagnosis, and interventions.
- ✿ Care plan was updated on regular intervals.

# The Year 1999-2007

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# Initial Assessment and Health History

Patient Name: _____		Case N°: _____
NURSING ADMISSION PHYSICAL ASSESSMENT		
NEUROSENSORY		Nursing Diagnosis
<b>Level of Consciousness:</b> <input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented/Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stuporous <input type="checkbox"/> Comatose <input type="checkbox"/> Others : _____ <b>Pupils:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal Reactive to light : Right eye <input type="checkbox"/> No <input type="checkbox"/> Yes Left eye <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Eyes:</b> <input type="checkbox"/> Clear <input type="checkbox"/> Draining <input type="checkbox"/> Others : _____ <b>Speech:</b> <input type="checkbox"/> Normal / Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Aphasic <input type="checkbox"/> Inappropriate <input type="checkbox"/> Others : _____ <b>Sleep / Rest :</b> <input type="checkbox"/> Denies problem <input type="checkbox"/> Problems as : _____		<input type="checkbox"/> Altered sensory perception (16) <input type="checkbox"/> Altered sleep pattern (17) <input type="checkbox"/> Impaired communication (6) <input type="checkbox"/> Altered thought process (18) <input type="checkbox"/> Altered comfort (5) <input type="checkbox"/> Potential physical injury (10) <input type="checkbox"/> Self care deficit (15) <input type="checkbox"/> Impaired tissue integrity (13) <input type="checkbox"/> Impaired physical mobility (11) <input type="checkbox"/> Altered bowel elimination (3)
OXYGENATION		
<b>Cardiovascular</b> <input type="checkbox"/> No abnormalities assessed Heart Rhythm : <input type="checkbox"/> Irregular <input type="checkbox"/> Others : _____ Neck Veins : <input type="checkbox"/> Distended Others : <input type="checkbox"/> Vertigo <input type="checkbox"/> Syncope <input type="checkbox"/> Others : _____ <input type="checkbox"/> Pacemaker <input type="checkbox"/> Other cardiac devices : _____ Pulses : <input type="checkbox"/> Not felt at (specify) : _____		<input type="checkbox"/> Self care deficit (15) <input type="checkbox"/> Altered sleep pattern (17) <input type="checkbox"/> Altered fluid volume (8) <input type="checkbox"/> Altered cardiac function (4) <input type="checkbox"/> Altered comfort (5) <input type="checkbox"/> Altered tissue perfusion (19) <input type="checkbox"/> Activity intolerance (1) <input type="checkbox"/> Potential physical injury (10) <input type="checkbox"/> Altered respiratory function (14)
<b>Respiratory</b> <input type="checkbox"/> No abnormalities assessed Breathing : <input type="checkbox"/> Labored <input type="checkbox"/> Dyspnea <input type="checkbox"/> Rapid <input type="checkbox"/> Shallow Quality : <input type="checkbox"/> Orthopnea <input type="checkbox"/> Accessory muscles used <input type="checkbox"/> Pain on Inspiration - Expiration <input type="checkbox"/> Others : _____ Breath sounds : <input type="checkbox"/> Crackles Rt - Lt <input type="checkbox"/> Diminished Rt - Lt <input type="checkbox"/> Wheezes Rt - Lt <input type="checkbox"/> Absent Rt - Lt Cough : <input type="checkbox"/> Yes : <input type="checkbox"/> Productive <input type="checkbox"/> Non productive <input type="checkbox"/> Sputum color _____ Tubes/ Devices : _____		<input type="checkbox"/> High risk for infection (9) <input type="checkbox"/> Altered body temperature (2) <input type="checkbox"/> Ineffective coping (7) <input type="checkbox"/> Knowledge deficit (21)
ELIMINATION		
<b>Bowel :</b> <input type="checkbox"/> No abnormalities assessed Date of last bm: _____ Frequency: _____ <input type="checkbox"/> Constipation <input type="checkbox"/> Laxative use <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Bloody stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Incontinence <input type="checkbox"/> Ostomy (Type) : _____ <input type="checkbox"/> Others _____ <b>Bowel Sounds :</b> <input type="checkbox"/> Absent at ( specify) _____ <b>Abdomen :</b> <input type="checkbox"/> Tender <input type="checkbox"/> Distended <input type="checkbox"/> Rigid <input type="checkbox"/> Others : _____ <b>Bladder :</b> <input type="checkbox"/> No abnormalities assessed <input type="checkbox"/> Distended <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Painful <input type="checkbox"/> Retention <input type="checkbox"/> Hematuria		<input type="checkbox"/> Altered bowel elimination (3) <input type="checkbox"/> Impaired tissue integrity (13) <input type="checkbox"/> Altered nutrition (12) <input type="checkbox"/> Altered body temperature (2) <input type="checkbox"/> High risk for infection (9) <input type="checkbox"/> Altered urine elimination (20) <input type="checkbox"/> Altered fluid volume (8) <input type="checkbox"/> Knowledge deficit (21)

**American University of Beirut Medical Center  
Nursing Services  
Nursing Care Plan**

Patient Name: \_\_\_\_\_ Bed N°: \_\_\_\_\_ Case N°: \_\_\_\_\_

**Discharge Planning**  
The patient will be able to return to pre-illness living arrangements or cope with disease condition .

**The patient and / or family will :**  
☐ be aware of appropriate discharge arrangements as evidenced by verbalizing what services are being arranged .  
☐ increase in coping abilities as evidenced by: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Arrange for :**  
☐ meds  
☐ environmental changes  
☐ treatments / equipment  
☐ health teaching  
☐ outpatient referral  
☐ diet  
☐ rehabilitation  
☐ others : \_\_\_\_\_

	Date / Initials		Patient Problems	Expected Outcomes	Nursing Interventions	Date / Initials D/C
	I	R				
<b>1-Activity</b>			<b>Activity intolerance</b> related to : <input type="checkbox"/> disease process <input type="checkbox"/> life style <input type="checkbox"/> age <input type="checkbox"/> anxiety / pain <input type="checkbox"/> meds / treatments <input type="checkbox"/> nutritional disorders <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> identify activities that increase fatigue <input type="checkbox"/> participate in required physical activities <input type="checkbox"/> employ safety measures <input type="checkbox"/> verbalize acceptance of limitations <input type="checkbox"/> demonstrate increased tolerance for ADLs <input type="checkbox"/> others : _____	<input type="checkbox"/> assess tolerance level <input type="checkbox"/> administer meds <input type="checkbox"/> plan activity/rest as needed <input type="checkbox"/> monitor vital signs <input type="checkbox"/> encourage breathing exercise & use of incentive spirometer <input type="checkbox"/> modify diet <input type="checkbox"/> others : _____	
<b>2-Body Temp.</b>			<b>Altered body temp.</b> related to : <input type="checkbox"/> trauma / disease <input type="checkbox"/> meds / treatment <input type="checkbox"/> environmental factors <input type="checkbox"/> extremes of age <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> maintain body temperature within normal limits for age <input type="checkbox"/> verbalize signs & symptoms of hypo / hyperthermia <input type="checkbox"/> identify risk factors <input type="checkbox"/> others : _____	<input type="checkbox"/> monitor temperature <input type="checkbox"/> maintain environmental temperature <input type="checkbox"/> maintain adequate intake <input type="checkbox"/> monitor accurate I/O <input type="checkbox"/> others : _____	
<b>3-Bowel Elimination</b>			<input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>Altered bowel elimination</b> related to : <input type="checkbox"/> meds / chemicals <input type="checkbox"/> impaired nutrition <input type="checkbox"/> disease process <input type="checkbox"/> immobility/pressure points <input type="checkbox"/> maturational age <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> verbalize understanding of contributing factors <input type="checkbox"/> participate in therapy <input type="checkbox"/> describe dietary requirements <input type="checkbox"/> establish as near to normal as possible a bowel function pattern <input type="checkbox"/> verbalize understanding of treatment <input type="checkbox"/> others : _____	<input type="checkbox"/> assess contributing factors <input type="checkbox"/> monitor bowel function <input type="checkbox"/> administer meds <input type="checkbox"/> increase bulk intake <input type="checkbox"/> initiate bowel programs <input type="checkbox"/> administer stool softeners <input type="checkbox"/> ambulate <input type="checkbox"/> increase fluid intake <input type="checkbox"/> others : _____	
<b>4-Cardiac Function</b>			<input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>Altered cardiac function</b> related to : <input type="checkbox"/> hemodynamic instability <input type="checkbox"/> dysrhythmia <input type="checkbox"/> hypo / hypertension <input type="checkbox"/> pulmonary congestion <input type="checkbox"/> fluid imbalance <input type="checkbox"/> altered cardiac output <input type="checkbox"/> others: _____	<b>The patient will exhibit stability in :</b> <input type="checkbox"/> hemodynamic status <input type="checkbox"/> cardiac rhythm & BP <input type="checkbox"/> fluid & electrolyte balance <input type="checkbox"/> The patient verbalizes reportable symptoms <input type="checkbox"/> others : _____	<b>Monitor :</b> <input type="checkbox"/> cardiac rhythms <input type="checkbox"/> vital signs <input type="checkbox"/> fluid balance ( I/O ) <input type="checkbox"/> daily weight <input type="checkbox"/> lab values / tests <input type="checkbox"/> others : _____	
<b>5-Comfort</b>			<b>Altered comfort</b> related to : <input type="checkbox"/> surgery / trauma <input type="checkbox"/> disease process <input type="checkbox"/> allergic reaction <input type="checkbox"/> meds / treatment <input type="checkbox"/> immobility/ pressure points <input type="checkbox"/> stress	<b>The patient will :</b> <input type="checkbox"/> verbalize and /or demonstrate relief of pain/ discomfort <input type="checkbox"/> demonstrate relaxation techniques <input type="checkbox"/> maintain pain at tolerance level <input type="checkbox"/> The patient will identify source of pain/ discomfort according to age <input type="checkbox"/> others : _____	<input type="checkbox"/> assess for comfort & pain relief pre / post intervention <input type="checkbox"/> administer meds <input type="checkbox"/> provide comfort measures <input type="checkbox"/> change position <input type="checkbox"/> prepare patient for procedures <input type="checkbox"/> initiate therapeutic play <input type="checkbox"/> others : _____	

STUDENT NAME: \_\_\_\_\_ CASE N°: \_\_\_\_\_

	Date / Initials		Patient Problems	Expected Outcomes	Nursing Interventions	Date / Initials D/C
	I	R				
			<b>Communication</b> <b>impaired</b> related to : <input type="checkbox"/> disease process <input type="checkbox"/> sensory deficit <input type="checkbox"/> treatments <input type="checkbox"/> anger / anxiety / pain <input type="checkbox"/> language barrier <input type="checkbox"/> maturational age <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> demonstrate increased ability to communicate <input type="checkbox"/> use alternative communication methods <input type="checkbox"/> use hearing aids <input type="checkbox"/> demonstrate increased ability to understand <input type="checkbox"/> others : _____	<input type="checkbox"/> use techniques to promote hearing / understanding <input type="checkbox"/> provide alternative methods of communication <input type="checkbox"/> consult speech therapy <input type="checkbox"/> address problems / fears <input type="checkbox"/> request help of translator <input type="checkbox"/> assist with hearing aids <input type="checkbox"/> others : _____	
			<b>Ineffective coping</b> ( anxiety ) related to : <input type="checkbox"/> impaired cognition <input type="checkbox"/> sensory overload <input type="checkbox"/> assault to self esteem <input type="checkbox"/> hospitalization <input type="checkbox"/> lack of support / conflict <input type="checkbox"/> maturational age <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> acknowledge importance of behavior change <input type="checkbox"/> verbalize feelings <input type="checkbox"/> identify obstacles <input type="checkbox"/> identify personal strength <input type="checkbox"/> demonstrate less anxiety <input type="checkbox"/> others : _____	<input type="checkbox"/> provide non-judgmental environment <input type="checkbox"/> give positive feedback <input type="checkbox"/> consult psychotherapy <input type="checkbox"/> encourage patient to discuss ideas & fears <input type="checkbox"/> remove excess stimulation <input type="checkbox"/> others : _____	
			<input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>Altered fluid volume</b> <input type="checkbox"/> Excess <input type="checkbox"/> Deficit related to : <input type="checkbox"/> inadequate I/O <input type="checkbox"/> altered tissue integrity <input type="checkbox"/> inadequate nutrition <input type="checkbox"/> disease process <input type="checkbox"/> vomiting / diarrhea <input type="checkbox"/> meds / treatments <input type="checkbox"/> environmental conditions <input type="checkbox"/> maturational age <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> demonstrate no signs of fluid imbalance <input type="checkbox"/> verbalize knowledge of related / contributing factors <input type="checkbox"/> verbalize understanding of dietary & fluid instructions & meds prescribed <input type="checkbox"/> others : _____	<input type="checkbox"/> assess vital signs <input type="checkbox"/> record weight daily <input type="checkbox"/> record accurate I/O <input type="checkbox"/> monitor lab values <input type="checkbox"/> change position <input type="checkbox"/> consult dietician <input type="checkbox"/> assess LOC <input type="checkbox"/> monitor fluid intake <input type="checkbox"/> restricted <input type="checkbox"/> increased <input type="checkbox"/> others : _____	
			<input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>High risk for infection</b> related to : <input type="checkbox"/> wound/surgery/trauma <input type="checkbox"/> invasive lines/treatment <input type="checkbox"/> environmental conditions <input type="checkbox"/> maturational age <input type="checkbox"/> disease process <input type="checkbox"/> perinatal exposure <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> be free from infection during hospitalization <input type="checkbox"/> verbalize factors that may increase the risk of infection <input type="checkbox"/> demonstrate adequate personal hygiene & precaution techniques <input type="checkbox"/> others : _____	<input type="checkbox"/> assess signs & symptoms of infection <input type="checkbox"/> identify related factors & mode of transmission <input type="checkbox"/> monitor vital signs <input type="checkbox"/> monitor lab values <input type="checkbox"/> apply precaution technique <input type="checkbox"/> apply universal precaution <input type="checkbox"/> others : _____	
			<b>Potential physical injury</b> related to <input type="checkbox"/> weakness / fatigue <input type="checkbox"/> maturational age <input type="checkbox"/> meds / treatment <input type="checkbox"/> sensory deficits <input type="checkbox"/> pain <input type="checkbox"/> disease process <input type="checkbox"/> prolonged bed rest <input type="checkbox"/> environmental hazards <input type="checkbox"/> others : _____	<b>The patient will :</b> <input type="checkbox"/> remain free from injury during hospitalization <input type="checkbox"/> remain calm during restraint <input type="checkbox"/> be unrestrained as soon as possible <input type="checkbox"/> identify potential factors for injury <input type="checkbox"/> verbalize an intent to practice selective preventive measures <input type="checkbox"/> others : _____	<input type="checkbox"/> assess orientation X 3 & comprehensive ability <input type="checkbox"/> institute fall precaution <input type="checkbox"/> pad side rails as needed <input type="checkbox"/> implement restraint protocol <input type="checkbox"/> administer meds <input type="checkbox"/> assess sensory impairment <input type="checkbox"/> control age related hazards <input type="checkbox"/> orient to room setting <input type="checkbox"/> others : _____	

Patient Name: _____		Case N°: _____			
Date / Initials		Patient Problems	Expected Outcomes	Nursing Interventions	Date / Initials
I	R				
11- Mobility		<b>Impaired physical mobility</b> related to: <input type="checkbox"/> disease process <input type="checkbox"/> treatment / meds <input type="checkbox"/> pain / fatigue <input type="checkbox"/> maturational age <input type="checkbox"/> others :	<b>The patient will :</b> <input type="checkbox"/> use assistive devices correctly <input type="checkbox"/> request assistance with ambulation <input type="checkbox"/> demonstrate measures to increase mobility <input type="checkbox"/> verbalize acceptance of limitations <input type="checkbox"/> others :	<input type="checkbox"/> provide progressive mobilization <input type="checkbox"/> provide safety measures <input type="checkbox"/> institute fall precaution <input type="checkbox"/> perform range of motion <input type="checkbox"/> encourage use of affected extremity <input type="checkbox"/> others :	
12- Nutrition		<input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>Altered nutrition</b> related to: <input type="checkbox"/> difficulty chewing/ swallowing <input type="checkbox"/> nausea / vomiting <input type="checkbox"/> disease / surgery <input type="checkbox"/> inadequate sucking reflex <input type="checkbox"/> parental neglect <input type="checkbox"/> congenital abnormalities <input type="checkbox"/> others :	<b>The patient will</b> maintain adequate nutritional status as indicated by : <input type="checkbox"/> weight maintenance <input type="checkbox"/> improved appetite <input type="checkbox"/> demonstrating understanding of diet modifications <input type="checkbox"/> others :	<input type="checkbox"/> weigh patient <input type="checkbox"/> monitor % of meals & tolerance <input type="checkbox"/> assess preferences <input type="checkbox"/> provide supplements <input type="checkbox"/> administer tube feeding <input type="checkbox"/> consult dietician <input type="checkbox"/> administer meds <input type="checkbox"/> provide oral hygiene <input type="checkbox"/> feed baby <input type="checkbox"/> provide parenteral nutrition <input type="checkbox"/> others :	
13- Tissue Integrity		<input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>Impaired tissue integrity</b> related to : <input type="checkbox"/> decreased mobility <input type="checkbox"/> environmental conditions <input type="checkbox"/> maturational age <input type="checkbox"/> disease process <input type="checkbox"/> meds / treatments <input type="checkbox"/> radiation therapy <input type="checkbox"/> others :	<b>The patient's skin integrity</b> will be maintained / improved during hospitalization <input type="checkbox"/> The patient / family demonstrate optimal skin-care routine. <input type="checkbox"/> The patient will verbalize factors related to skin maintenance <input type="checkbox"/> others :	<input type="checkbox"/> assess skin condition <input type="checkbox"/> position <input type="checkbox"/> instruct patient/ family about importance of nutrition, hygiene & mobility <input type="checkbox"/> use pressure therapy device <input type="checkbox"/> provide pressure sore care <input type="checkbox"/> use protective measures <input type="checkbox"/> modify diet <input type="checkbox"/> maintain fluid balance <input type="checkbox"/> others :	
14- Respiratory Status		<input type="checkbox"/> Actual <input type="checkbox"/> Potential <b>Altered respiratory status</b> related to : <input type="checkbox"/> post-op status / CBR <input type="checkbox"/> mechanical obstruction <input type="checkbox"/> meds / treatments <input type="checkbox"/> pain / anxiety <input type="checkbox"/> disease process <input type="checkbox"/> maturational age <input type="checkbox"/> prematurity / croup <input type="checkbox"/> complicated cesarean delivery <input type="checkbox"/> others :	<b>The patient will</b> <input type="checkbox"/> maintain adequate ventilation during hospitalization <input type="checkbox"/> demonstrate methods to prevent acquiring infection <input type="checkbox"/> have clear airways <input type="checkbox"/> perform breathing exercises <input type="checkbox"/> others :	<b>Monitor :</b> <input type="checkbox"/> respiratory status <input type="checkbox"/> character of sputum <input type="checkbox"/> ABGs / lab values <input type="checkbox"/> vital signs <input type="checkbox"/> start O2 therapy <input type="checkbox"/> perform chest physiotherapy <input type="checkbox"/> encourage use of incentive spirometer <input type="checkbox"/> ambulate <input type="checkbox"/> suction <input type="checkbox"/> administer meds <input type="checkbox"/> if assisted, assess readiness for weaning <input type="checkbox"/> others :	
15- Self Care		<b>Self care deficit</b> related to : <input type="checkbox"/> disease process <input type="checkbox"/> restrictive devices <input type="checkbox"/> surgical procedures <input type="checkbox"/> pain / anxiety <input type="checkbox"/> visual disorders <input type="checkbox"/> depression / anxiety <input type="checkbox"/> immobility <input type="checkbox"/> maturational age <input type="checkbox"/> others :	<input type="checkbox"/> The patient will assist with progressive self care during hospitalization <input type="checkbox"/> The patient care needs will be met during hospitalization <input type="checkbox"/> The patient verbalizes the need for total care . <input type="checkbox"/> The patient will participate physically / verbally in self care <input type="checkbox"/> others :	<input type="checkbox"/> assess strengths and limitations <input type="checkbox"/> assess causative or contributing factors <input type="checkbox"/> evaluate ability to participate in ADL <input type="checkbox"/> involve patient / family in care <input type="checkbox"/> administer meds <input type="checkbox"/> use adaptive equipment <input type="checkbox"/> others :	

Patient Name: _____		Case N°: _____			
Date / Initials		Patient Problems	Expected Outcomes	Nursing Interventions	Date / Initials
I	R				
16- Sensory Perception		<b>Sensory - perceptual alteration</b> related to: <input type="checkbox"/> impaired sensory organs <input type="checkbox"/> disease process <input type="checkbox"/> treatment/ meds <input type="checkbox"/> pain / stress <input type="checkbox"/> social isolation <input type="checkbox"/> others :	<b>The patient will :</b> <input type="checkbox"/> identify & eliminate potential risk factors <input type="checkbox"/> demonstrate decreased symptoms of sensory overload <input type="checkbox"/> verbalize understanding of treatment <input type="checkbox"/> others :	<input type="checkbox"/> provide calm environment <input type="checkbox"/> assess source of disturbance <input type="checkbox"/> provide relaxing measures <input type="checkbox"/> orient & assess orientation x3 <input type="checkbox"/> involve patient in provided care <input type="checkbox"/> others :	
17- Sleep Disturbance		<b>Altered sleep pattern</b> related to: <input type="checkbox"/> pain / discomfort <input type="checkbox"/> meds / treatment <input type="checkbox"/> anxiety / fear <input type="checkbox"/> disease process <input type="checkbox"/> equipment/devices <input type="checkbox"/> environmental changes <input type="checkbox"/> immobility <input type="checkbox"/> others :	<b>The patient will :</b> <input type="checkbox"/> describe factors that inhibit sleep <input type="checkbox"/> identify techniques to induce sleep <input type="checkbox"/> report an optimal balance of rest and activity <input type="checkbox"/> maintain adequate sleep pattern according to age <input type="checkbox"/> others :	<input type="checkbox"/> reduce noise <input type="checkbox"/> establish day time plan for activities & rest <input type="checkbox"/> decrease intake of fluids if voiding at night disrupts <input type="checkbox"/> administer meds <input type="checkbox"/> provide comfort measures <input type="checkbox"/> explain to child concept of night & share fear <input type="checkbox"/> others :	
18- Thought Process		<b>Altered thought process</b> related to : <input type="checkbox"/> personality disorder <input type="checkbox"/> disease process <input type="checkbox"/> anxiety / fear <input type="checkbox"/> substance abuse <input type="checkbox"/> abuse / neglect <input type="checkbox"/> maturational age <input type="checkbox"/> others :	<b>The patient will :</b> <input type="checkbox"/> sustain no injury <input type="checkbox"/> demonstrate improved mental status <input type="checkbox"/> demonstrate improved LOC <input type="checkbox"/> demonstrate improved judgement ability <input type="checkbox"/> engage in selfcare activities <input type="checkbox"/> identify anxiety related conditions <input type="checkbox"/> others :	<input type="checkbox"/> assess LOC <input type="checkbox"/> provide safe environment <input type="checkbox"/> develop plan for ADL <input type="checkbox"/> assist in decision making <input type="checkbox"/> promote stimulation <input type="checkbox"/> orient & provide sensory & social interaction <input type="checkbox"/> others :	
19- Tissue Perfusion		<b>Altered tissue perfusion</b> related to : <input type="checkbox"/> disease process <input type="checkbox"/> immobilization <input type="checkbox"/> treatment / meds <input type="checkbox"/> environmental conditions <input type="checkbox"/> maturational age <input type="checkbox"/> others :	<b>The patient will :</b> <input type="checkbox"/> report improved sensation in limbs <input type="checkbox"/> report acceptable level of comfort <input type="checkbox"/> verbalize reportable signs <input type="checkbox"/> verbalize contributing factors <input type="checkbox"/> verbalize factors that enhance circulation <input type="checkbox"/> others :	<input type="checkbox"/> assess extremities <input type="checkbox"/> assess pain <input type="checkbox"/> position patient <input type="checkbox"/> ambulate <input type="checkbox"/> administer meds <input type="checkbox"/> perform active/passive exercises <input type="checkbox"/> consult dietician <input type="checkbox"/> others :	
20- Urinary Elimination		<b>Altered patterns of urinary elimination</b> related to : <input type="checkbox"/> disease process <input type="checkbox"/> trauma / surgery <input type="checkbox"/> meds / treatment <input type="checkbox"/> pregnancy <input type="checkbox"/> stress / fear/pain <input type="checkbox"/> maturational age <input type="checkbox"/> others :	<b>The patient will :</b> <input type="checkbox"/> verbalize understanding of condition <input type="checkbox"/> identify causative/related factors <input type="checkbox"/> demonstrate techniques to prevent infection <input type="checkbox"/> manage care of catheter/stoma and other appliances <input type="checkbox"/> maintain as near to normal as possible urinary elimination <input type="checkbox"/> others :	<input type="checkbox"/> assess and monitor causative factors <input type="checkbox"/> assess and monitor signs & symptoms <input type="checkbox"/> offer bedpan/urinal <input type="checkbox"/> provide comfort measures <input type="checkbox"/> provide catheter/stoma care <input type="checkbox"/> maintain fluid balance (I/O) <input type="checkbox"/> observe vital signs & voiding pattern <input type="checkbox"/> others :	
21- Knowledge Deficit		<b>High risk for ineffective management of therapeutic regimen</b> related to : <input type="checkbox"/> personal characteristics <input type="checkbox"/> insufficient knowledge <input type="checkbox"/> lack of readiness/access <input type="checkbox"/> culture/ beliefs <input type="checkbox"/> maturational age <input type="checkbox"/> complexity of regimen <input type="checkbox"/> others :	<b>The patient/family will :</b> <input type="checkbox"/> verbalize/demonstrate understanding of meds, activity, disease process, self care, pain management, food & drug/drug interaction <input type="checkbox"/> relate an intent to practice health behaviors needed or desired <input type="checkbox"/> utilize available educational resources <input type="checkbox"/> describe reportable signs & symptoms <input type="checkbox"/> verbalize understanding of discharge instructions given	<input type="checkbox"/> assess knowledge deficit <input type="checkbox"/> identify factors to enhance learning <b>Teach patient regarding :</b> <input type="checkbox"/> disease process & reportable signs <input type="checkbox"/> lifestyle & environmental changes <input type="checkbox"/> treatment regimen <input type="checkbox"/> meds: dosage, frequency, side effects, drug/drug & drug/food interaction <input type="checkbox"/> follow-up care needed <input type="checkbox"/> activities & exercises <input type="checkbox"/> diet	



**Figure 1**

[illegible]

Case No. \_\_\_\_\_

Infant/Pediatric / Neonatal disorders ( add for age group)			Case No:
Date / Initials	P	R	
22- Family Process			<p><b>Patient Problems</b>            Altered family process            related to            disease process            treatment/ trauma            death/separation            change in role            others</p> <p><b>Expected Outcomes</b>            The patient/ family will :            verbalize feelings            participate in care            facilitate return to role            maintain functional system for            mutual support for each member            others</p> <p><b>Nursing Interventions</b>            assist with appraisal            of situation            create a private environment            involve family in care            help to modify expectations            provide needed guidance            others</p> <p>Date / Initials            D/C</p>
23- Growth			<p><b>Altered growth &amp; development</b> related to            disease process            treatments            parent/child conflict            child neglect            others</p> <p><b>The patient / family will :</b>            demonstrate an increase in            behaviors in personal social            language cognition &amp; motor            activities appropriate to age            others</p> <p><b>Nursing Interventions</b>            assess &amp; monitor the            patient's developmental level            provide activities to meet            age related development            modify diet</p>
24- Breast - Feeding			<p><b>Ineffective breast-feeding</b> related to :            breast anomaly            infant prematurity            surgery / meds            maternal fatigue/anxiety            knowledge deficit            inadequate nutrition            multiple births            others</p> <p><b>The mother will :</b>            decide on appropriate method            of feeding            identify activities to promote            successful breastfeeding            identify factors that inhibit            adequate breastfeeding            maintain adequate nutrition            &amp; fluid intake            others</p> <p><b>Nursing Interventions</b>            assess knowledge            discuss advantages            assist during feedings            provide breast care            provide breast pump            provide diet            maintain adequate intake            others</p>
25- Parenting			<p><b>Altered parenting</b>            related to            separation from            nuclear family            marital problems            emotional problems            disease process            others :</p> <p><b>The patient / family will :</b>            share feelings regarding parenting            identify causative factors            describe appropriate measures            identify resources for assistance            others :</p> <p><b>Nursing Interventions</b>            assess behaviors            encourage sharing difficulties            assess abuse            give age related instructions            encourage participation in care            explain procedures            discuss disciplinary measures            others</p>
<b>Additional Problems ( specify ) :</b>			

Additional Problems ( specify ) :	

Structure	opacity	width

33546 / 5

**Nursing Care Plan Updates** (place your initials under the related shift)

Patient Name: \_\_\_\_\_

Date	DIMPY		

Patient Name: \_\_\_\_\_

Case No:

[illegible]

## KEY

[illegible]

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# Our Experience with the First Project

## Education, Training, and Evaluation

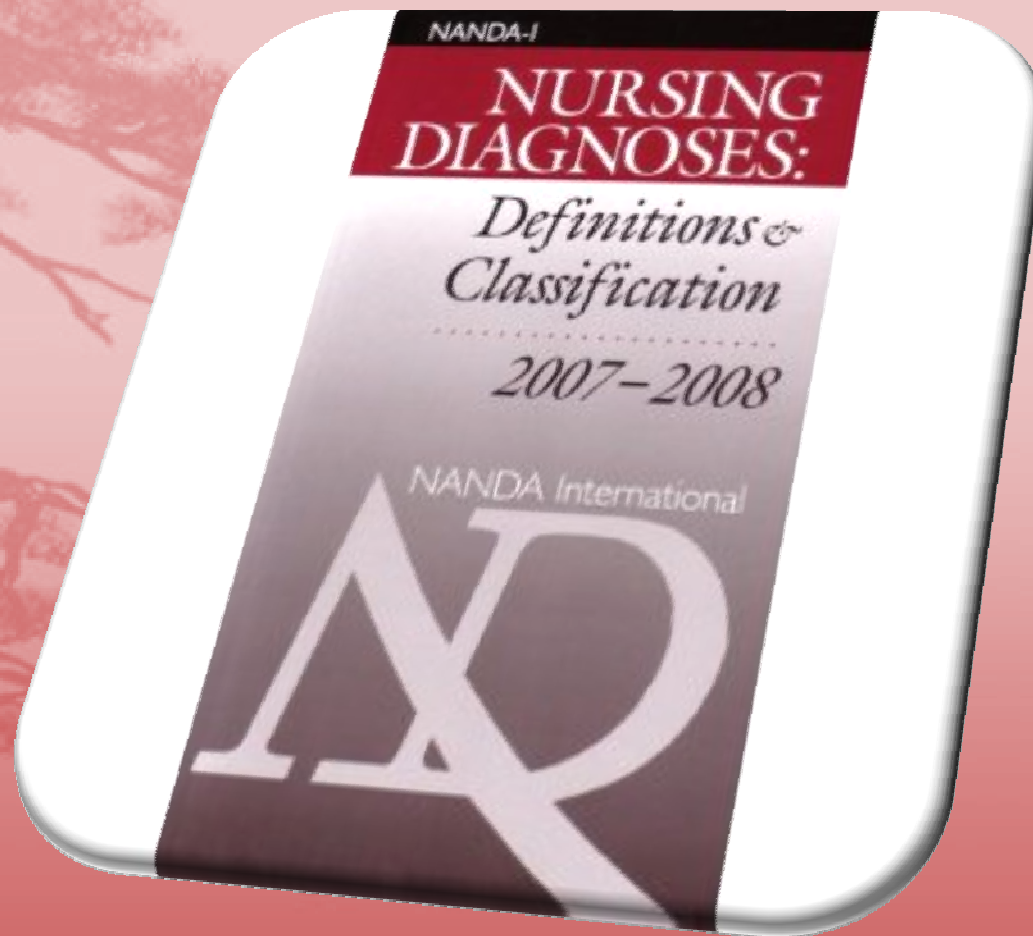
- ✿ Workshops to all nurses
- ✿ Training to unit champions
- ✿ NMs discussing cases with nurses through care plan application
- ✿ NSA rounding on units and discussing selected cases as well
- ✿ Quality people performing audits
- ✿ Put in policy

## Challenges and Areas of Improvement

- ✿ Checking just to check
- ✿ No connection between assessment findings-diagnosis-interventions-outcome measures.
- ✿ Process did not encourage critical thinking

# The Year 2007-2011

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# Care Plan Document

American University of Beirut Medical Center  
Nursing Services

Patient Name: \_\_\_\_\_  
Patient No. \_\_\_\_\_  
Bed No. \_\_\_\_\_

**Nursing Care Plan** (check what is applicable)

**Discharge Planning**  
A process to decide what a patient needs for a smooth move from one level of care to another. It is a multidisciplinary approach to the development and implementation of a comprehensive plan for the safe discharge of the patient from a health care facility and for continuing safe and effective care at an alternate site.

The discharge planning includes:

<input type="checkbox"/> Health promotion <input type="checkbox"/> Health status <input type="checkbox"/> Treatment and care <input type="checkbox"/> Coping abilities <input type="checkbox"/> Unresolved problems	<input type="checkbox"/> Medications <input type="checkbox"/> Diet <input type="checkbox"/> Activity <input type="checkbox"/> Follow up <input type="checkbox"/> Lifestyle and environmental changes	<input type="checkbox"/> Equipment <input type="checkbox"/> Pain management <input type="checkbox"/> In case of emergency / questions please contact: _____
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**Knowledge Deficit**  
Education is essential to engage clients in their health care delivery and to increase the compliance rate in the treatment process. It includes developing and providing instructions and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups or communities.

N.B. The provided education shall be documented in the Multidisciplinary Patient/Family Education Record

<input type="checkbox"/> Health promotion <input type="checkbox"/> Health/disease status <input type="checkbox"/> Self care <input type="checkbox"/> Pain management	<input type="checkbox"/> Safety <input type="checkbox"/> Diagnostic procedures <input type="checkbox"/> Treatment and care <input type="checkbox"/> Environmental changes	<input type="checkbox"/> Medications <input type="checkbox"/> Diet <input type="checkbox"/> Activity <input type="checkbox"/> Equipment (specify): _____
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30902

NCP Revised 2007



Sample Diagnosis:

**Stickers**



### Activity Intolerance

☐ Actual

Initiated Date/ Initials	Resolved Date/ Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>Assess patient's to perform activities of daily living (ADLs)</li> <li>Vital signs monitoring (T, HR, RR, BP)</li> <li>Encourage energy conservation procedures: (ex. sitting while bathing)</li> <li>Assist and encourage participation in self care</li> <li>Provide uninterrupted rest periods</li> <li>Promote exercise and ambulation</li> <li>Oxygen therapy</li> <li>Consult dietitian</li> <li>Psychological support</li> <li>Environmental safety</li> </ul>

#### Outcomes

- ☐ Activity tolerance  
☐ Endurance  
☐ Energy conservation  
☐ Self care (ADL)

30916

### Decreased Intracranial Adaptive Capacity

☐ Actual

Initiated Date/ Initials	Resolved Date/ Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>Maintain Intracranial Pressure: 10-15 mmHg</li> <li>Maintain Cerebral Perfusion Pressure &gt;50mmHg</li> <li>Monitor ICP waveform</li> <li>Position to maintain good body alignment</li> <li>Provide break between activities that increase ICP</li> </ul>

#### Outcomes

- ☐ Intracranial and cerebral perfusion pressure within normal range

30936

### Altered Bowel Elimination (specify)

☐ Actual

☐ Potential

- ☐ Constipation  
☐ Bowel Incontinence  
☐ Diarrhea

Initiated Date/ Initials	Resolved Date/ Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>Bowel assessment</li> <li>Monitor bowel frequency, characteristic and amount of stool</li> <li>Monitor laboratory results/ Take specimens, as appropriate</li> <li>Monitor intake / out put</li> <li>Insert NG tube</li> <li>Encourage fluid intake _____</li> <li>Encourage exercise</li> <li>Bowel Irrigation/ training</li> <li>Ostomy care</li> <li>Consult dietitian</li> <li>Administer medications</li> </ul>

#### Outcomes

- ☐ Bowel continence  
☐ Bowel elimination Q \_\_\_\_

30913

### Aspiration Impaired Swallowing

☐ Actual

☐ Potential

Initiated Date/ Initials	Resolved Date/ Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>Monitor gag/ cough reflex/ swallowing ability</li> <li>Monitor level of consciousness/ neurologic status</li> <li>Respiratory monitoring/ patent airway</li> <li>Keep suction set up available</li> <li>Enteral tube feeding</li> <li>Positioning upright during feeding and after feeding</li> <li>Encourage aspiration precaution diet</li> <li>Feed in small amounts</li> <li>Break or crush pills before administration</li> <li>Avoid drinking with straws</li> <li>Instruct patient not to talk during eating</li> <li>Consult dietitian</li> <li>Keep tracheal cuff inflated</li> <li>Oral hygiene</li> </ul>

#### Outcomes

- ☐ Aspiration control  
☐ Improved swallowing status

30908

### Decreased Cardiac Output

☐ Actual

Initiated Date/ Initials	Resolved Date/ Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>Evaluate chest pain; intensity, radiation, duration, precipitating, and alleviating factors</li> <li>Monitor pace maker functioning</li> <li>Monitor cardiac rhythm</li> <li>Hemodynamic monitoring</li> <li>Neurologic assessment</li> <li>Monitor arterial blood gases</li> <li>Vital signs monitoring (T, HR, RR, BP)</li> <li>Fluid/electrolyte monitoring</li> <li>Monitor laboratory results</li> <li>Medication administration</li> </ul>

#### Outcomes

- ☐ Cardiac pump effectiveness  
☐ Circulation status  
☐ Organ perfusion

30918

### Imbalanced Nutrition (specify)

☐ Actual

☐ Potential

Initiated Date/ Initials	Resolved Date/ Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>More than body requirements</li> <li>Less than body requirements</li> <li>Monitor appetite</li> <li>Assess food preferences</li> <li>Weight monitoring</li> <li>Determine body mass index (BMI)</li> <li>Consult dietitian</li> <li>Monitor laboratory results</li> <li>Facilitate loss/ gain of weight</li> <li>Exercise promotion</li> <li>Encourage substitution of undesirable habits</li> <li>Reward patient when goals are attained</li> <li>Fluid/electrolyte management</li> <li>Enteral tube feeding</li> <li>Total parental nutrition administration</li> <li>Bottle feeding/breast feeding</li> <li>Medication administration</li> </ul>

#### Outcomes

- ☐ Nutrients are provided meeting metabolic needs  
☐ Weight control

30906

### Impaired Physical Mobility

☐ Actual

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>● Assess activity levels</li> <li>● Plan activities according to energy level</li> <li>● Exercise promotion/ perform range of motion</li> <li>● Consult physiotherapy</li> </ul>
		<ul style="list-style-type: none"> <li>● Provide assistance in self care activities</li> <li>● Perform range of motion</li> <li>● Environmental safety</li> <li>● Positioning</li> </ul>
<hr/>		
Outcomes		
<input type="checkbox"/> Ambulation <input type="checkbox"/> Improved mobility level		
<input type="checkbox"/> Active joint movement		

30920

### Pain

☐ Actual

☐ Acute

☐ Chronic

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>● Pain assessment: (location, characteristics, onset, duration, frequency, quality, intensity, alleviating and aggravating factors, radiation)</li> <li>● Observe for nonverbal cues of discomfort</li> <li>● Explore patient's knowledge and belief about pain</li> <li>● Determine the impact of pain on quality of Life</li> <li>● Determine the interference of pain on ADLs</li> <li>● Distraction/ music therapy/ relaxation therapy</li> <li>● Heat/ cold application</li> </ul>
		<ul style="list-style-type: none"> <li>● Recommend appropriate relaxing positions</li> <li>● Control environmental factors that influence response to discomfort</li> <li>● Emotional support</li> <li>● Medication administration/ patient control analgesia</li> <li>● Mutual goal setting</li> <li>● Pain management procedures</li> </ul>
<hr/>		
Outcomes		
<input type="checkbox"/> Alleviation or a reduction of pain to a level of comfort that is acceptable to the patient <input type="checkbox"/> Pain score _____		

30925

### Infection

☐ Potential

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>● Vital signs monitoring (T, HR, RR, BP)</li> <li>● Monitor laboratory results</li> <li>● Take specimens as appropriate</li> <li>● Maintain isolation precaution techniques</li> <li>● Limit number of visitors/ eliminate fresh flowers</li> <li>● Neutropenic precautions</li> <li>● Inspect skin and mucous membranes</li> <li>● Chest physiotherapy and cough enhancement</li> <li>● Oral hygiene</li> </ul>
		<ul style="list-style-type: none"> <li>● Promote sufficient nutritional intake</li> <li>● Wound care</li> <li>● Perineal care</li> <li>● Post prandial care</li> <li>● Pressure ulcer care</li> <li>● Tube care</li> <li>● Medication administration</li> <li>● Report suspected infections to Infection control department, as appropriate</li> </ul>
<hr/>		
Outcomes		
<input type="checkbox"/> Immune Status <input type="checkbox"/> WBC = _____ <input type="checkbox"/> Prevention of infection		

30905

### Falls

☐ Potential

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>● Initiate fall interventions as per hospital policy</li> <li>● Keep the 4 side rails up</li> <li>● Lock the bed brakes</li> <li>● Provide adequate nighttime lighting</li> <li>● Lower the bed to its lowest position at all times when not providing care</li> <li>● Assess high risk patients every 2 hrs and</li> <li>● Provide toilet assistance</li> </ul>
		<ul style="list-style-type: none"> <li>● Keep the call bell button within patient's reach at all times</li> <li>● Place the patient's personal belonging and phone within reach at all times</li> <li>● Keep clutter - free, well-lit environment</li> <li>● Advise patient to wear safe footwear</li> <li>● Educate the patient and/ or family on "fall management prevention"</li> </ul>
<hr/>		
Outcomes		
<input type="checkbox"/> Fall Prevention		

30923

### Altered Urinary Elimination (specify)

☐ Actual

☐ Potential

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>● Urinary assessment</li> <li>● Monitor urine out put</li> <li>● Monitor laboratory results/ take specimens, as appropriate</li> <li>● Bladder training/ irrigation/ pelvic muscles exercise</li> </ul>
		<ul style="list-style-type: none"> <li>● Urinary catheterization/ care</li> <li>● Perineal care</li> <li>● Medication administration</li> </ul>
<hr/>		
Outcomes		
<input type="checkbox"/> Urinary continence <input type="checkbox"/> Urinary elimination		

30914

### Impaired Skin Integrity

☐ Actual

☐ Potential

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions
		<ul style="list-style-type: none"> <li>● Skin assessment (color, temperature, moisture, texture, integrity)</li> <li>● Pressure ulcer assessment/ prevention/ care</li> <li>● Positioning</li> <li>● Keep bed linen clean, dry and wrinkle free</li> <li>● Fluid/ electrolyte monitoring</li> <li>● Skin hygiene and care</li> <li>● Radiation site care</li> </ul>
		<ul style="list-style-type: none"> <li>● Diarrhea management</li> <li>● Wound/ ostomy care</li> <li>● Cast/ traction care</li> <li>● Incision site care</li> <li>● Perineal care</li> <li>● Sitz bath</li> <li>● Medication administration</li> </ul>
<hr/>		
Outcomes		
<input type="checkbox"/> Intact skin integrity		

30910

# Case Study

## History:

H.C., a 70 year old woman who has just to the emergency department.

## Chief complaint:

Her daughter tells you that she is not arousable, having diarrhea and difficulty breathing since yesterday

## V/S:

BP: 100/40mmHg

HR:100bpm

RR: 35breaths/min

T: 39°C

## Physical examination findings:

- ✿ Stuporous opening eyes to pain
- ✿ Shallow breathing with decreased air entry
- ✿ Cyanotic
- ✿ Concentrated urine( after inserting an indwelling catheter)

# Assessment Findings: Documentation

American University of Beirut Medical Center  
Nursing Services  
Patient Assessment / Reassessment - Medical Surgical

Patient Label:

Patient Name: \_\_\_\_\_ Patient Number: \_\_\_\_\_

	□ 7-3 □ 3-11 □ 11-7 □ Acuity 2 Date: _____ Time: _____	□ 7-3 □ 3-11 □ 11-7 □ Acuity 2 Date: _____ Time: _____	□ 7-3 □ 3-11 □ 11-7 □ Acuity 2 Date: _____ Time: _____
<b>Neuromuscular</b>	<input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met LOC <input type="checkbox"/> Conscious <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stupor <input type="checkbox"/> Unresponsive/comatose <input type="checkbox"/> Disoriented to _____ <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time Pupils <input type="checkbox"/> Non reactive <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Unequal reactive Sensory <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Altered vision <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Altered hearing <input type="checkbox"/> Rt <input type="checkbox"/> Lt Movement <input type="checkbox"/> Unstable gait <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Limited ROM Speech <input type="checkbox"/> Slurred <input type="checkbox"/> Aphasia <input type="checkbox"/> Incomprehensible	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met LOC <input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stupor <input type="checkbox"/> Unresponsive/comatose <input type="checkbox"/> Disoriented to _____ <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time Pupils <input type="checkbox"/> Non reactive <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Unequal reactive Sensory <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Altered vision <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Altered hearing <input type="checkbox"/> Rt <input type="checkbox"/> Lt Movement <input type="checkbox"/> Unstable gait <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Limited ROM Speech <input type="checkbox"/> Slurred <input type="checkbox"/> Aphasia <input type="checkbox"/> Incomprehensible	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met LOC <input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stupor <input type="checkbox"/> Unresponsive/comatose <input type="checkbox"/> Disoriented to _____ <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time Pupils <input type="checkbox"/> Non reactive <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Unequal reactive Sensory <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Altered vision <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Altered hearing <input type="checkbox"/> Rt <input type="checkbox"/> Lt Movement <input type="checkbox"/> Unstable gait <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Limited ROM Speech <input type="checkbox"/> Slurred <input type="checkbox"/> Aphasia <input type="checkbox"/> Incomprehensible
<b>Behavioral</b>	<input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Restlessness <input type="checkbox"/> Agitation <input type="checkbox"/> Unclear thinking <input type="checkbox"/> Fear <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Illusions/ Hallucinations <input type="checkbox"/> Delayed responsiveness <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Insomnia	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Restlessness <input type="checkbox"/> Agitation <input type="checkbox"/> Unclear thinking <input type="checkbox"/> Fear <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Illusions/ Hallucinations <input type="checkbox"/> Delayed responsiveness <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Insomnia	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Restlessness <input type="checkbox"/> Agitation <input type="checkbox"/> Unclear thinking <input type="checkbox"/> Fear <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Illusions/ Hallucinations <input type="checkbox"/> Delayed responsiveness <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Insomnia
<b>Respiratory</b>	<input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met Breathing Pattern <input type="checkbox"/> Apnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Dyspnea <input type="checkbox"/> Shallow <input type="checkbox"/> Orthopnea <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscle use Unclear Breath Sounds <input type="checkbox"/> Wheezes <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Crackles <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Diminished <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Absent <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Productive Sputum <input type="checkbox"/> Whitish <input type="checkbox"/> Yellowish <input type="checkbox"/> Brownish <input type="checkbox"/> Thick <input type="checkbox"/> Frothy <input type="checkbox"/> Bloody <input type="checkbox"/> Blood tinged	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met Breathing Pattern <input type="checkbox"/> Apnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Dyspnea <input type="checkbox"/> Shallow <input type="checkbox"/> Orthopnea <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscle use Unclear Breath Sounds <input type="checkbox"/> Wheezes <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Crackles <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Diminished <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Absent <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Productive Sputum <input type="checkbox"/> Whitish <input type="checkbox"/> Yellowish <input type="checkbox"/> Brownish <input type="checkbox"/> Thick <input type="checkbox"/> Frothy <input type="checkbox"/> Bloody <input type="checkbox"/> Blood tinged	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met Breathing Pattern <input type="checkbox"/> Apnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Dyspnea <input type="checkbox"/> Shallow <input type="checkbox"/> Orthopnea <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscle use Unclear Breath Sounds <input type="checkbox"/> Wheezes <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Crackles <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Diminished <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Absent <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Productive Sputum <input type="checkbox"/> Whitish <input type="checkbox"/> Yellowish <input type="checkbox"/> Brownish <input type="checkbox"/> Thick <input type="checkbox"/> Frothy <input type="checkbox"/> Bloody <input type="checkbox"/> Blood tinged

\* For Initial Assessment all systems need to be assessed

Patient Name:

Patient Number:

	□ Not indicated for assessment* □ Criteria Met <input type="checkbox"/> Criteria Not Met	□ Not indicated for assessment □ Criteria Met <input type="checkbox"/> Criteria Not Met	□ Not indicated for assessment □ Criteria Met <input type="checkbox"/> Criteria Not Met
<b>Cardiovascular</b>	Regular pulse, normal heart sounds, no edema, capillary refill <3 seconds, no JVD, no ascitis, palpable peripheral pulses (DP and Radial) <input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Abnormal heart sounds Peripheral pulses non palpable Radial <input type="checkbox"/> Rt <input type="checkbox"/> Lt DP <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> JVD <input type="checkbox"/> Delayed Capillary Refill <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Grade 1: Quickly disappears <input type="checkbox"/> Grade 2: Remains 10-15 Seconds <input type="checkbox"/> Grade 3: Remains 1-2 Minutes <input type="checkbox"/> Grade 4: Remains 2-5 Minutes	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Abnormal heart sounds Peripheral pulses non palpable Radial <input type="checkbox"/> Rt <input type="checkbox"/> Lt DP <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> JVD <input type="checkbox"/> Delayed Capillary Refill <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Grade 1: Quickly disappears <input type="checkbox"/> Grade 2: Remains 10-15 Seconds <input type="checkbox"/> Grade 3: Remains 1-2 Minutes <input type="checkbox"/> Grade 4: Remains 2-5 Minutes	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Abnormal heart sounds Peripheral pulses non palpable Radial <input type="checkbox"/> Rt <input type="checkbox"/> Lt DP <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> JVD <input type="checkbox"/> Delayed Capillary Refill <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Grade 1: Quickly disappears <input type="checkbox"/> Grade 2: Remains 10-15 Seconds <input type="checkbox"/> Grade 3: Remains 1-2 Minutes <input type="checkbox"/> Grade 4: Remains 2-5 Minutes
<b>Gastro - Intestinal</b>	<input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Rigid <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence <input type="checkbox"/> Oral mucositis Bowel Sounds <input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Rigid <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence <input type="checkbox"/> Oral mucositis Bowel Sounds <input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Rigid <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence <input type="checkbox"/> Oral mucositis Bowel Sounds <input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive
<b>Genito - Urinary</b>	<input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Oliguria <input type="checkbox"/> Dysuria <input type="checkbox"/> Anuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Dark colored urine <input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence <input type="checkbox"/> Retention <input type="checkbox"/> Abnormal discharge	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Oliguria <input type="checkbox"/> Dysuria <input type="checkbox"/> Anuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Dark colored urine <input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence <input type="checkbox"/> Retention <input type="checkbox"/> Abnormal discharge	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Oliguria <input type="checkbox"/> Dysuria <input type="checkbox"/> Anuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Dark colored urine <input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence <input type="checkbox"/> Retention <input type="checkbox"/> Abnormal discharge
<b>Pain</b>	For Initial Assessment <input type="checkbox"/> Refer to Nursing Data Base For Reassessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met (Pain Identified)	<input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met (Pain Identified)	<input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met (Pain Identified)
<b>Integumentary</b>	<input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Clammy <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundice <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Erythema <input type="checkbox"/> Hematoma <input type="checkbox"/> Palpable mass <input type="checkbox"/> Lesion/laceration <input type="checkbox"/> Pressure ulcer	<input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Clammy <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundice <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Erythema <input type="checkbox"/> Hematoma <input type="checkbox"/> Palpable mass <input type="checkbox"/> Lesion/laceration <input type="checkbox"/> Pressure ulcer	<input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Clammy <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundice <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Erythema <input type="checkbox"/> Hematoma <input type="checkbox"/> Palpable mass <input type="checkbox"/> Lesion/laceration <input type="checkbox"/> Pressure ulcer
<b>Surgical Wound/Incision</b>	<input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness <input type="checkbox"/> Dehiscence Discharge <input type="checkbox"/> Bloody <input type="checkbox"/> Purulent <input type="checkbox"/> Sero-sanguineous <input type="checkbox"/> Biliary <input type="checkbox"/> Serous <input type="checkbox"/> Odorous Amount <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Excessive	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness <input type="checkbox"/> Dehiscence Discharge <input type="checkbox"/> Bloody <input type="checkbox"/> Purulent <input type="checkbox"/> Sero-sanguineous <input type="checkbox"/> Biliary <input type="checkbox"/> Serous <input type="checkbox"/> Odorous Amount <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Excessive	<input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness <input type="checkbox"/> Dehiscence Discharge <input type="checkbox"/> Bloody <input type="checkbox"/> Purulent <input type="checkbox"/> Sero-sanguineous <input type="checkbox"/> Biliary <input type="checkbox"/> Serous <input type="checkbox"/> Odorous Amount <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Excessive
	RN Name and Signature	RN Name and Signature	RN Name and Signature

KEY: LOC: Level of Consciousness, Rt: Right, Lt: Left, ROM: Range of Motion, DP: Dorsalis Pedis, JVD: Jugular Vein Distention, PERRLA: Pupils equal round reactive to light and accommodation.



# Diagnosis and Outcome Selection

- ☐ Impaired Gaseous Exchange  
☐ Ineffective Airway Clearance  
☐ Ineffective Breathing Pattern

- ☐ Dysfunctional Weaning Response  
☐ Impaired Spontaneous Ventilation

☐ Actual

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions	Outcomes
		<ul style="list-style-type: none"> <li>● Auscultate breath sounds/ respiratory monitoring</li> <li>● ABGs interpretation</li> <li>● Hemodynamic monitoring</li> <li>● Vital signs monitoring (T, HR, RR, BP)</li> <li>● Assess level of consciousness</li> <li>● Inspect mucous membranes and skin for cyanosis</li> <li>● Monitor chest x-ray findings</li> <li>● Allow for rest periods between activities</li> <li>● Positioning</li> </ul>	<ul style="list-style-type: none"> <li>● Chest physiotherapy/ cough enhancement</li> <li>● Incentive spirometry</li> <li>● Oxygen therapy/ mechanical ventilation</li> <li>● Suctioning - airway</li> <li>● Fluid management</li> <li>● Aspiration precaution</li> <li>● Medication administration</li> <li>● Emotional support</li> </ul>
			<input type="checkbox"/> Electrolyte balance <input type="checkbox"/> Acid/ base balance <input type="checkbox"/> Gas exchange

30917

## Ineffective Thermoregulation (specify)

☐ Actual

☐ Potential

☐ Hypothermia

☐ Hyperthermia

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions	Outcomes
		<ul style="list-style-type: none"> <li>● Monitor vital signs (T, HR, RR, BP)</li> <li>● Monitor skin color</li> <li>● Monitor laboratory results</li> <li>● Monitor ABGs</li> <li>● Monitor intake/output</li> <li>● Hemodynamic monitoring</li> </ul>	<ul style="list-style-type: none"> <li>● New born care/monitoring</li> <li>● Environmental considerations/ warm blankets</li> <li>● Fluid management</li> <li>● Apply compressors as needed</li> <li>● Medication administration</li> </ul>
			<input type="checkbox"/> Thermoregulation <input type="checkbox"/> T = _____

30904

## Ineffective Tissue Perfusion: (specify)

☐ Actual

- ☐ Cerebral  
☐ Cardiopulmonary

- ☐ Gastro Intestinal  
☐ Peripheral  
☐ Renal

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions	Outcomes
		<ul style="list-style-type: none"> <li>● Vital signs monitoring (T, HR, RR, BP)</li> <li>● Hemodynamic monitoring</li> <li>● ABGs monitoring</li> <li>● Monitor intake/output</li> <li>● Monitor laboratory results</li> </ul>	<ul style="list-style-type: none"> <li>● Monitor for signs for decreased tissue perfusion</li> <li>● Oxygen therapy</li> <li>● Blood/ blood products administration</li> <li>● Medication administration</li> </ul>
			<input type="checkbox"/> Tissue perfusion

30922

## Fluid Volume

☐ Actual

☐ Potential

☐ Deficit

☐ Excess

Initiated Date/Initials	Resolved Date/Initials	Nursing Interventions	Outcomes
		<ul style="list-style-type: none"> <li>● Assess skin integrity, capillary refill, thirst, mucous membranes</li> <li>● Vital signs monitoring (T, HR, RR, BP)</li> <li>● Monitor intake/output</li> <li>● Monitor for distended neck veins, crackles in lungs and peripheral edema</li> <li>● Hemodynamic monitoring</li> <li>● ABGs monitoring</li> <li>● Monitor laboratory results</li> </ul>	<ul style="list-style-type: none"> <li>● Administer fluid and electrolyte, as appropriate</li> <li>● Blood/ blood products administration</li> <li>● Encourage/ restrict oral hydration</li> <li>● Medication administration</li> <li>● Weight patient as ordered</li> <li>● Resuscitation: fetus</li> <li>● Dialysis</li> </ul>
			<input type="checkbox"/> Fluid balance

30909

# Intervention Selection

## Interventions on various forms:

- \* Selected from care plan stickers
- \* Documented on Physician's order sheet, Flow sheet, medication administration record...

Progress note → **PIO** format

Problem  
Intervention  
Outcome

# Education, Training, and Follow Up

## Education, Training, and Evaluation

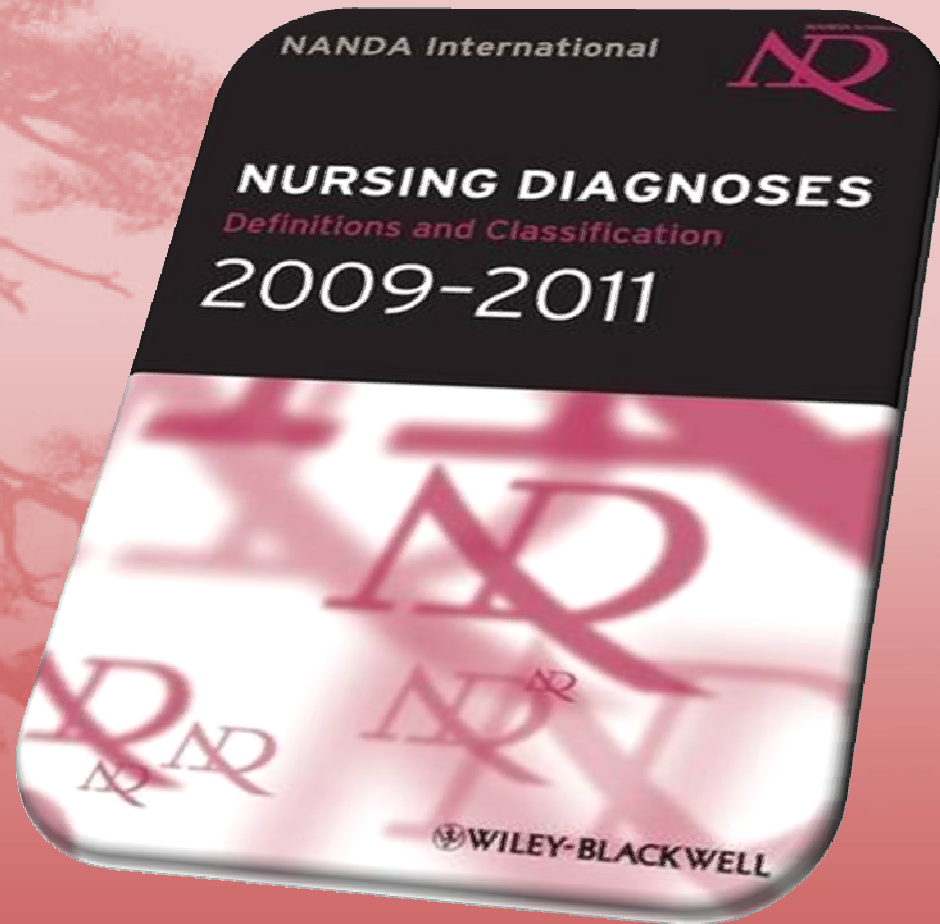
- ✿ Education to all nurses through a workshop.
- ✿ Training provided by Clinical Educators and Advanced Practice Nurses to all Staff Nurses.
- ✿ Colorful boards on the units were designed to have sticker-holders mounted to.
- ✿ Staff nurses select only pertinent diagnosis (go-and-get)
- ✿ Nursing Quality Improvement Officers, CEs and APNs periodically perform audits and case discussions.
- ✿ Revise policy

## Challenges and Areas of Improvement

- ✿ Gaps in linking the diagnosis with interventions and outcomes (but less than the previous approach).
- ✿ Absence of interdisciplinary diagnosis.

# The Year 2011

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# Our Plan

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- ✿ Have a look at the new NANDA classification
- ✿ Review, and revise our current Care Plan Structure to be aligned with the latest version.

Involving staff nurses, nurse managers, clinical educators, advanced practice nurses, nursing quality improvement, information technology, and medical records.