CARE PLANNING

GROUP 4:

Members: Arsh, Charankamaljit, Devon, Janna, Jas, Mandeep (Mandy), Monika, Sarah & Trixia
What is a Care Plan?
Nursing Care Plans

★ **Purpose**: provide direction for individual patient care through patient-specific needs based on data collection from assessments, medication charts, and lab/diagnostic results
★ They aid in communicating and organizing actions of the dynamic nursing staff, and allow for keeping the staff updated on the care plan
★ If a care plan is not documented, there is no proof that the care was given, as well as, insurers will not pay for any undocumented care
To the right is an example of a care plan used at Kwantlen Polytechnic University.

Care plan formats may differ in appearance depending on the health authority or facility you are in, but generally contain nursing diagnoses, goals/outcomes, interventions, and evaluations.

Care plans help nurses to think critically, teach nurses how to care for a patient on a more personal level and prioritize care/interventions so that the patient's health status can be improved.

Assists students with pulling out information from various scientific disciplines while learning how to think critically and use the nursing process to find solutions to problems.
Example - How to Complete a Care Plan

The following video is very informative video that explains how to complete a care plan.

https://www.youtube.com/watch?v=07Z4ywfmLg8
Assessment

★ Assessment is a gathering of data of a patient by using different techniques such as a physical assessment, blood results, x-rays & health history

★ The assessment data consists of objective and subjective data

★ Objective data is data that can be gathered and confirmed:
  ➢ Temperature
  ➢ Blood pressure
  ➢ Respirations
  ➢ Weight
  ➢ Age
  ➢ Gender
  ➢ Sores/wounds
  ➢ Appearance/skin color

★ Subjective data is information that we gather from the patient through verbal communication
  ➢ Pain is subjective data
  ➢ Dizziness- pt is complaining of dizziness but data is not confirmed
  ➢ Shortness of breath (SOB)
Nursing Diagnosis

★ A list of statements, made from clinical judgments about actual human response or potential individual, family, and/or community experiences or responses to health problems

★ Based on the nursing diagnosis, nurses intervene to obtain patient specific outcomes.

★ A proper nursing diagnosis statement contains a
  ○ 1) Diagnosis
  ○ 2) Related to (RT) and an
  ○ 3) As evidence by (AEB)

★ Used to define the right plan of care, allows for interventions to be made, and patient outcomes to happen

(Example on Slide 12)
Nursing Goals/Outcomes

★ **Goal/Outcome**: what the nurse hopes to achieve through nursing interventions, in other words, it’s a desired outcome for the patient's condition.

★ The goals can be short term and long term goals that is measurable and achievable for example, a patient who is total care has a pressure ulcer on the sacrum. The goal is to decrease pressure by reposition the patient q2 hrs.

★ Goals are usually general, for example: the patient’s nutritional status will improve over all.

★ Outcomes are usually more specific, for example: the patient will gain 10lbs by a certain date

(Example on Slide 12)
Nursing Interventions

- Specific tasks, actual treatment or actions that will occur to help the patient achieve the goals and outcomes
- They contain a date for a time frame, an action verb, the where and what of the intervention, as well as, the signature of the nurse
- For example: for pressure ulcers, a nursing intervention will be to use preventative measures for at risk patients like pressure reducing mattress, chair cushions, respostion q2hrs, nutritional and skin assessment in order to reduce and relieve pressure
- Through critical thinking, a nurse is able to determine the outcome that is going to help the patient make improvements in his/her health.
- The nursing interventions can include any part of patient’s life (ex: nutrition, psychosocial, elimination needs, medication, physical well-being, and ADL’s)

(Example on Slide 12)
Evaluation

★ Patient’s health care professionals will determine the progress towards goals and outcomes and the effectiveness of the care plan
★ They determine whether or not the interventions should be continued, changed or terminated
★ Care plan can be modified as needed

(Example on Slide 12)
Rationale*

★ Scientific reasoning for selecting a specific nursing intervention and justifying the reason for your intervention
★ Usually added to help students learn and apply their knowledge towards their care plans so they know why they are choosing specific actions for their patient’s care
  ○ Ex: for a patient whose O2 Sat is 89%, RR-16, BP 130/78, Heart rate-72, Temp-37.1°C, the nursing intervention is to position the client with head of bed elevated, in a semi-fowler's position as tolerated
  ○ So the rationale based on the nursing intervention will be semi-fowler's position allows increased lung expansion because the abdominal contents are not crowding the lungs
Example of Nursing Care Plan

1. Example obtained from Nurse Bass’ youtube video, that we simplified and reworded: https://www.youtube.com/watch?v=-tFq1ru0sLA

Nursing Diagnosis Statement: A patient was shot in the left lung, which caused the lung to collapse. The collapsed lung caused an ineffective breathing pattern RT air and fluid in the pleural cavity from the gunshot. The wound caused a disruption of the fluid between the visceral and parietal pleura due to the acute change in negative pressure of the pleural cavity resulting in atelectasis (collapsing) of the alveoli in the (L) lung AEB a hydro pneumothorax revealed by a chest x-ray, shortness of breath (SOB), and labored breathing.

Goal: For the patient to experience a normal breathing pattern //

Expected Outcome: 1) Patient SpO2 will remain above 90% for the remainder of the shift. 2) Patient will remain at regular rate, rhythm and depth of respiration for remainder of shift,

Interventions: 1) Administer O2 @ 2.5L/min via NC (nasal cannula) per physician order. 2) Get patient out of bed and to the bedside chair so they are mobile after post-op for lung expansion promotion. 3) Sit patient up in high-fowler’s position to keep SpO2 above 90%.

Evaluation: Patient’s SpO2 stayed above 90% for the entire shift, as well as, the rate, rhythm and depth of respirations were regular. The interventions can continue so the patient keeps a normal breathing pattern.

2. Another example of a care plan: http://www.rncentral.com/nursing-library/careplans/bec/#
Another example of a Care Plan of a person diagnosed with Pneumonia

<table>
<thead>
<tr>
<th>NURSING DIAGNOSIS</th>
<th>OUTCOME CRITERIA</th>
<th>INTERVENTIONS</th>
<th>RATIONALE for INTERVENTIONS</th>
<th>EVALUATION</th>
</tr>
</thead>
</table>
| Ineffective airway clearance RT pneumonia AEB orthopnea, chest xray, crackles in lung fields, SOB, cough | Short-Term Goal: **PT will verbalize importance of ambulation and fluid intake and deep breathing as a means of loosening secretions.**  
Long-Term Goal: **PT will demonstrate a productive cough and will begin to clear lung fields as evidenced by CXR and lung fields being clear to auscultation.** | RN will instruct the pt on the proper method of deep breathing and encourage the patient to practice deep breathing.  
RN will assist the patient to ambulate twice during shift.  
RN will monitor breathing and O2 sats to insure proper oxygenation.  
RN will allow and instruct on importance of rest periods prior to eating and ADLs.  
RN will encourage coughing and fluid intake. | Deep breathing will aid in clearing lung fields and providing the body with adequate ventilation.  
Ambulation will aid in loosening secretions.  
Closely monitoring breathing and O2 sats will aid the nurse in monitoring for acute changes in respiratory status.  
Rest periods prior to eating will aid the patient in restoring oxygenation and decrease orthopnea.  
Continuous coughing and fluid intake will aid in loosening secretions and aid in improving ventilation. | PT demonstrated an improved understanding of the importance of fluid intake and deep breathing and ambulation. PT resisted ambulating but her daughter was able to aid in getting the pt out of bed and moving. |

**ASSESSMENT DATA**

**Subjective**
- Pt reports SOB, pt denies pain, pt states she is tired and weak

**Objective**
- Crackles in lung fields, orthopnea, continuous cough with no expectorant, RR 18, P71, Temp 98.9, pCO2 33
References


[RegisteredNurseRN]. (2015, June 11). Nursing Care Plan Tutorial | How to Complete a Care Plan in Nursing School [Video File]. Retrieved from https://www.youtube.com/watch?v=07Z4ywfMgLg8