

**CCRI**

**NURSING PROGRAM**

**THE USE OF**

**NURSING PROCESS**

**IN**

**CLINICAL PREPARATION**

**AND**

**CARE PLAN DEVELOPMENT**

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## A Message to Students and New Faculty

Welcome to the Department of Nursing at the Community College of Rhode Island.

The following presentation is the result of an ambitious project to standardize information and instruction in the use of the Nursing Process in the nursing curriculum here at the Community College. Nursing Process is the driving force in the provision of nursing care throughout the spectrum of patient care. It is the unique language of nursing and an integral part the professional identity of nurses.

Because the Department of Nursing is large and diverse in its geographical distribution, this booklet was designed to unify the approaches to instruction of the Nursing Process. It is our goal to provide you with the information necessary for you to work successfully in the clinical setting. It is suggested that you refer to this booklet for continued guidance in the process of acquiring skill in nursing process along with your required Nursing Diagnosis text. It is our profound hope that this will result in an enjoyable and successful learning experience.

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# GUIDELINES FOR CLINICAL ASSIGNMENT PREPARATION

As you ready yourself to go into the hospital and care for patients, you will be challenged to prepare for the delivery of patient care in a compassionate and intelligent manner. As you might remember, in the first few weeks of NURS 1010 you learned how to move, bathe, and communicate with patients. These fundamental skills are the foundations of patient care and what you will bring to the clinical setting when you enter the nursing home or hospital.

Hospitalized patients are admitted because they are acutely ill and cannot be safely managed outside the facility. Patients in hospitals today are sicker and require more skills both from the doctors and nurses who care for them. Because patients are acutely ill, it is necessary that you monitor or watch them closely based on ‘why’ they came into the hospital. You need to prepare yourself for caring for these sick patients. It involves a good deal of preliminary work before you even arrive at the hospital. The nursing faculty have developed a form to use for your preparation. It is called the **Preliminary Data Sheet (PDS)**. It incorporates all of the information necessary for you to safely and efficiently care for the patient. Because nursing is a profession with legal implications in practice, it is important that patient care is addressed with due diligence. Your job will be to fill in the blanks with the required information as you prepare for your assignment. Since you will be working in the clinical setting under the guidance and license of your clinical instructor, it is important that you prepare carefully. All of the faculty require that you complete this sheet before caring for your patient(s). Most all the faculty believes it needs to be done the day before so that you have sufficient time to gather your information and learn about your patient’s health problem(s) *thoroughly* prior to caring for them. This format makes for a positive and abundantly meaningful learning experience.

## **Preliminary Data Sheet (see Appendix A)**

Filling out the front section of the PDS is relatively simple because it requires merely filling in the blanks with necessary information about your patient from their medical record and/or kardex. This is your “Do List” for clinical. There is a vast array of resources to use such as *Admission Physical Exam* by the physician, *Admission Nursing Assessment* and of course, recent entries in the progress notes. Each hospital has its unique terminology for these resources and your instructor will show you where to retrieve this information in your clinical orientation to the hospital. But here are some general guidelines to help you prepare this part of your assignment.

**Reason for Admission:** This is a short narrative of the symptoms the patient had that brought them to the emergency room or physician’s office. It is **NOT** the medical diagnosis. For example: *worsening cough and fever for 3 days* or *sudden onset of chest pain and diaphoresis*.

**Medical Diagnosis:** Select the primary reason the patient is admitted. For example: *COPD exacerbation*, or *Appendicitis*. Keep in mind that some patients may enter the hospital with two active medical problems. This is not uncommon in the elderly.

**Surgery:** List the dates and look up the procedure definition. Avoid listing surgical procedures that were long ago such as the 89 year old patient who had his tonsils out as a child.

**Concurrent Medical Problems:** These are other medical conditions or diagnoses that may influence patient care. For example, Hypertension(HTN), Diabetes (DM), Depression, Osteoarthritis (OA), Coronary Artery Disease (CAD).

**Nursing Care:** Most of this information in this section such as diet, activity orders, vital signs, and I&O are general care requirements in hospital admissions. These orders are part of the physician's orders for care of his/her patient. **Additional Nursing Actions** are more specific to the patient's individualized needs. For example: *Glucometer checks AC and HS, specific wound care orders or oxygen therapy*. In summary, these orders fall into the category of *Dependent Nursing Actions* which are dictated to nursing by the physician (MD), nurse practitioner (NP) or physician's assistant (PA) as a collaborative approach to patient care.

**Diagnostic Tests and Medications:** Your instructor will review how this section is to be completed.

The back side of the PDS requires more creative input on your part and is a bit of a challenge in the beginning. We hope the information that follows will help you develop Focused Assessment, Planned Nursing Actions and Patient Education easily and successfully. Keep in mind that practice will make this process easier for you.

## Focused Assessment - Planned Nursing Actions - Patient Education

Developing focused assessments appropriate to your patient is a critical element in providing safe, intelligent and competent care. It is what you will learn and we will teach you toward becoming a competent nurse. Unfortunately, there is no one book that you can use that has Focused Assessments already written up for your use. Some authors of nursing text use the terms: clinical features, clinical findings, signs and symptoms, physical manifestations or defining characteristics. For example, the text: ***Straight A's in Medical Surgical Nursing*** is a great book to help you develop Focused Assessments. This text uses the term 'clinical findings'. It presents the medical or surgical problem in brief outline form which is great for developing your focus but remember you need to use your Medical Surgical text from class to get a total and more detailed explanation of your patient's problem. So...as a beginning nurse we will teach you how to develop Focused Assessments so that you will be prepared to care for acutely ill patients in the hospital. As you progress through your studies in the nursing program here at CCRI, you will begin to build upon this foundation of knowledge you have gained called 'nursing care' through each new nursing course you take. Each course will add to the sophistication of your

knowledge so that by the time you are ready to graduate and practice nursing on your own, you will have evolved a knowledge base that will make you a safe and competent nurse. So let's begin.

## Focused Assessment

What *exactly* is a Focused Assessment? A Focused Assessment is a group of physical and/or mental manifestations that cue the nurse as to where to focus or pay attention to in her assessment and care of the patient based upon their reason for admission. Remember, the patient who is hospitalized is acutely ill. The nurse always begins care by assessing her patients but a focused assessment helps narrow her attention to the specific reason why the patient is hospitalized. Usually, the focused assessment can fall into three major categories:

- a.) acute medical or surgical diagnosis (example: pneumonia or appendicitis)
- b.) a complication of a diagnosis (example: A patient with Deep Vein Thrombosis (DVT) is at risk for a pulmonary embolus (PE).
- c.) a high risk medical or surgical treatment or intervention (example: TPN therapy, chemotherapy, IV anticoagulation, peritoneal dialysis)

In NURS 1010, the focused assessments you will develop will be very basic because you are learning basic physical assessment skills and general nursing concepts such as pain, hygiene, thermal interventions, etc. As you progress successfully into NURS 1020, your Focused Assessments will become more specific because you will be learning about diseases and their uniqueness in adult health. Below are two examples of a Focused Assessment for a patient with pneumonia. The first would be appropriate for NURS 1010 (a basic respiratory system assessment) whereas the second example would be appropriate for NURS 1020 (more specific disease focus). Just remember that Focused Assessment is what you expect to see, observe or detect in your patient with this medical problem NOT what you will do to treat it.

### **NURS 1010: Respiratory Assessment**

Assess for adventitious lung sounds

Assess for cyanosis, pallor,  
and decreased capillary refill

Assess for changes in RR

Assess for cough

### **NURS 1020: Pneumonia**

Assess for adventitious lung sounds (crackles, wheezes, rhonchi and tactile fremitus)

Assess for mental status change

Assess for decreased SaO<sub>2</sub>

Assess for cough and sputum production (color, amount, odor)

Assess for pleuretic pain

Assess for fever, hypotension and tachycardia

Here's an example of a Focused Assessment for a patient receiving a treatment (Anticoagulation for a clot in the leg) that is high risk for injury/safety.

Anticoagulation Therapy

Assess for petechiae

Assess for bruising and bleeding (gums, urine, stool)

Assess for tachycardia, hypotension

### **Planned Nursing Actions**

Now that you know what a Focused Assessment is, how is it different from Planned Nursing Actions? Simply remember that 'Assessment' means clustered clinical data that has been gathered to help make inferences or decisions regarding the patient's medical or surgical condition. Planned Nursing 'Actions' on the other hand, means that you will do something deliberate with the knowledge that this action will achieve some value or goal toward patient care. These two teaching concepts of **Focused Assessment** and **Planned Nursing Actions** are different but must exist together. You may be confused in the beginning when developing these but your instructor will help you with this. In the above example of the Focused Assessment for the patient with Pneumonia, the following would be an appropriate Planned Nursing Action to follow the Focused Assessment.

**Planned Nursing Actions**

Check lung sounds Q4hours and prn

Pulse oximetry Q4 hours and prn

Encourage PO fluids

Maintain supplemental oxygen as ordered

Keep HOB elevated 15 to 20 degrees

Provide periods of rest after activity

Encourage coughing and deep breathing

Comparing the Focused Assessment and the Planned Nursing Actions for the patient with pneumonia, can you see the difference in these two? They are not alike but clearly they need each other for the nurse to deliver safe and competent care. By developing these two learning tools as a student, you will slowly and most assuredly, develop your knowledge about health care problems and how to manage these both from a medical and nursing perspective. This teaching tool will help you become a competent thinking nurse. But...we are not done yet!!!

### **Anticipated Learning Needs/Patient Education**

The last piece to this whole process called nursing is Patient Education. As beginning students in NURS 1010, we do not expect that you can do a great deal of

instruction and teaching with patients because you are learners yourselves. But, as you progress in NURS 1020, an important part of nursing care is teaching patients to care for themselves. Essentially, many patients will return home and those not capable of caring for themselves will need family at home or be placed in a safe environment such as a nursing home. It is the responsibility of nurses to teach patients how to care for themselves or their family member in order to prevent further admissions and illness or manage chronic diseases to prevent complications. This is a very important role for nurses and you need to begin your practice with the guidance of your clinical instructor. Patient Education falls into two categories: formal instruction and informal bedside teaching.

Formal instruction involves a very specific teaching plan and is usually done to initiate a new treatment plan. Usually it is done by a nurse, dietician, physical therapist, or other professional and many times requires written documents for patients to take with them. For example, a patient with diabetes must now learn how to take insulin. This would require a formal plan assessing knowledge, readiness to learn, implementation of a plan with written or video material and then evaluation of what the patient has learned.

Informal bedside instruction involves giving patient's information that will help them deal with the routine aspects of their care or illness. Both formal and informal teaching is of great value to patient care. Any time you are teaching patients, it is important that you first get the information approved by your instructor, especially any formal education. Most times, your instructor will need to consult with your patient's staff nurse to approve the teaching. Some hospital even have formal teaching program within the facility that patients can attend either as inpatients or outpatients. Informal teaching becomes part of your everyday knowledge and most times does not require your instructor. For example, telling a patient to avoid canned goods and luncheon meat who is on a Low Sodium diet does not need your instructor's approval provided you know your information is valid. How do you know it is valid? If you learned it from class or assigned reading, then it is valid! The ability to informally teach patients grows with experience. And then, of course, don't attempt to teach elderly patients with dementias. It doesn't work!!!

Most nursing text incorporate Patient Education as part of their information. Even faculty lectures identify education. As you move along in the nursing courses, your ability to teach will increase. A good gauge of your understanding of health problems is to know the subject matter well enough to teach it! Below is an example of Patient Education for our patient with Pneumonia.

#### **Patient Education/Pneumonia**

- Teach patient to avoid crowds during flu season
- Check to ascertain if patient received Pneumovax
- Review hand washing and use of Kleenex
- Instruct patient to consult PCP with early signs/symptoms of respiratory illness

## Common Student Questions about Clinical Assignment Preparation

### **Can a Nursing Diagnosis be a Focused Assessment?**

No...nay...never! A nursing diagnosis cannot be a focused assessment for several reasons. First, a Nursing Diagnosis is arrived at by first assessing your patient. You will not be assessing your patient until you arrive to care for them. A Focused Assessment is what you need to arrive with before caring for your patient so that you can safely care for them considering why they are in the hospital. Additionally, a Nursing Diagnosis is limited to nursing actions that can be independently instituted. Hospitalized patients are acutely ill and the nurse must also incorporate physician orders for nursing care (Dependent Actions) that will be part of patient care. This is called *Collaborative Practice*, nurses and physicians work together to deliver competent care to patients in helping them recover or learn to manage their illness. One cannot exist without the other. As much as nursing is a vital part of patient care, patients are admitted to hospitals for medical diagnoses, not nursing diagnoses.

### **Where do I start when developing Focused Assessment?**

First, you must investigate the patient's chart or kardex and find out why they came into the hospital. What was their major problem that caused the admission? Once you find the health care problem, go to your Medical/Surgical Nursing text and look up the problem. Read, re-read and read again so you understand it well enough to tell someone what it is. Look at all aspects of the problem. For example, etiology, diagnostic tests associated with the problem, signs and symptoms, complications, treatment (medications, diet, surgery, or other interventions), prognosis, etc.

### **Where do I find information to help me develop my Focused Assessments, Planned Nursing Actions or Patient Education?**

All of your information will come from your nursing texts required for your classes. Remember that the text will probably not use the word Focused Assessment. Look for other terms that mean the same thing such as clinical findings, signs and symptoms, etc. The same for 'Nursing Actions'; look under 'nursing management' or 'nursing care'. Use a variety of texts. Save all of your work for future reference. The more you investigate, the greater you will learn. Remember...know it well enough to teach it!!

### **What is the difference between Nursing Actions on the front of the Preliminary Data Sheet (PDS) and Planned Nursing Actions on the back of the PDS?**

The Nursing Actions on the front of the PDS are regarded as *Dependent* Nursing Actions or nursing activities ordered by the physician that the nurse is legally bound to fulfill. Most of these actions require a physician order and the nurse cannot legally complete the action without a physician's order in the hospital setting. For example, only a physician can order diet, activity, use of oxygen, dressing changes or blood sugar checks.

Planned Nursing Actions on the back of the PDS are considered to be *Independent* Nursing Actions or those nursing activities that do not require a physician's order. These activities are considered to be 'evidence-based practice' which means that scientific research has demonstrated that these activities promote health and wellness, and are beneficial to patient care. For example, elevating a patient's edematous legs, encouraging fluids in a patient with pneumonia, or, coughing and deep breathing a postoperative patient are all examples of independent nursing actions. Nurses can prescribe these actions in appropriate settings by virtue of the fact that research supports these actions as beneficial and a nurse's license grants them the privilege of making such judgments.

**What if my patient has more than one reason for admission? Can I have more than one Focused Assessment?**

Yes. In reality, most patients admitted to the hospital today are quite ill and have multiple illnesses or what is called 'co morbidities'. We suggest that you limit your Focused Assessment to no more than three (3) or three columns on the back side of the PDS. Remember that a Focused Assessment can be; (a.) an acute medical condition, (b.) a complication of an acute medical condition, or, (c.) a therapy, treatment or intervention that is high risk in terms of patient safety. You will need to select the most important focus for your care of that patient. Be aware that patient's change day to day. One day a patient might be relatively stable with one major focus. The next day they might be in critical condition. Delivery of health care is a dynamic ever-changing process.

8/07

COMMUNITY COLLEGE OF RHODE ISLAND

NURSING 1010/1020

**FUNCTIONAL HEALTH PATTERNS**

**GUIDELINES FOR NURSING ASSESSMENT**

Functional Health Patterns is a method of holistic assessment that provides information from a nursing rather than a medical perspective. Marjorie Gordon introduced a formal framework for assessing functional health patterns in 1982. She identified patterns of human function in 11 categories that address physical, psychological, spiritual and social needs. Rather than treating the illness or disease, nursing care is aimed at maintaining or improving the client's functional status in each of the 11 areas (Taylor et al, 2008 p.250).

Clustering of data by functional health patterns help you to identify problems responsive to nursing intervention and assign appropriate nursing diagnoses to dysfunctional patterns.

The following Functional Assessment Format was developed to assist you in organizing a complete client assessment based on: 1) objective findings, 2) the client's subjective knowledge of his health problems and 3) additional information from related sources.

Components of data collection include the nursing history and the nursing physical assessment. In doing a client assessment, we have provided categories and general questions to guide you in gathering data. These questions are in no way meant to be a complete list. You are expected to modify and/or expand your questioning in each functional area, individualizing your interview as your particular client's condition warrants it. You are encouraged to interview family and significant others to gather relevant data. You must also review the client's health record or chart to provide additional data. A thorough assessment identifies usual patterns or functions, and detects actual or potential alterations in the functional patterns. Upon completion of the functional assessment, the nurse will then interpret and analyzes the data gathered to formulate nursing diagnoses.

## FUNCTIONAL ASSESSMENT GUIDELINES

### 1. **Health Perception – Health Management Pattern**

Describes client's perceived patterns of general health status and well being. Adherence to preventive health practices.

- a. How has general health been? Any colds/illnesses in the past year?
- b. Most important things you do to stay healthy.
- c. Any use of cigarettes, alcohol, drugs?
- d. In the past, has it been easy to find ways to follow things doctors or nurses suggest?
- e. If appropriate: What do you think caused this illness? Actions taken when symptoms developed? Results of action?
- f. If appropriate: Things important to you while you are here? How can we be most helpful?

### 2. **Nutrition – Metabolic Pattern**

Describes patterns of food and fluid intake, fluid and electrolyte balance, skin integrity, general ability to heal.

- a. Typical daily food intake? (Describe)      Supplements?
- b. Typical daily fluid intake? (Describe)
- c. Weight loss/gain? (Amount)
- d. Appetite?
- e. Food or eating: Discomfort? Diet Restrictions? Allergies?
- f. IV? - rate, amount
- g. Drainage or gastric suction?
- h. Skin problems: lesions or dryness, surgical wounds, cellulitis
- i. Dental problems?
- j. Is there a particular health problem/medication which could affect fluid and electrolyte imbalance? Explain.
- k. Are there any indications/symptoms of a disturbance in fluid and electrolyte balance? (e.g. lab values, skin turgor etc.) Explain.
- l. What is the client's body temperature?
- m. Does the client have diabetes or a family history of diabetes?

### 3. **Elimination Pattern**

Describes patterns of excretory function of the bowel, bladder and skin.

- a. Bowel elimination pattern: frequency?, consistency?, color?, problems? discomfort? use of laxatives? Bowel sounds?
- b. Urinary elimination pattern: frequency?, color?, problems?, incontinence?
- c. Are there any special routines followed at home to help maintain normal elimination patterns?
- d. Is there a history of bowel or bladder elimination problems?
- e. Excess perspiration? Odor problems?

**4. Activity – Exercise Pattern**

Describes pattern of exercise, activity, leisure, recreation and ADL.

- a. What are your usual daily activities?
- b. Do you have sufficient energy for desired/required activities?
- c. What is your usual pattern of exercise?
- d. Do you have a history of respiratory or cardiac problems?
- e. Are you satisfied with your level of activity?
- f. Do you need an assistive device for walking?
- g. What do you do for leisure activities?
- h. Client’s ability for: (identify Functional Level Code for each)

Eating	Dressing/Grooming	Bathing	Bed mobility
Transferring	Ambulating	Drinking	Toileting

Assistive Devices: cane, walker, bedside commode

Functional Level Code

- Level 0: Independent
- Level 1: Requires use of equipment or assistive device
- Level 2: Requires assistance from another person
- Level 3: Requires assistance or supervision from another person and equipment or device
- Level 4: Is dependent/unable to participate

**5. Sleep – Rest Pattern**

Describes patterns of sleep, rest and relaxation.

- a. What is your usual pattern of sleep? Do you feel rested in the morning?
- b. Do you use sleep aids? Are you able to sleep through the night?
- c. Do you have trouble falling asleep?

**6. Cognitive – Perceptual Pattern**

Describes adequacy of sensory modes, such as vision, hearing, taste, touch, and smell, as well as perception and cognition.

- a. Do you have any difficulty with vision?
- b. Do you need glasses for reading or long distance?
- c. Do you have any difficulty with hearing? Do you use a hearing aid?
- d. What is your name? Where do you live? What brought you to the hospital?  
What day is it?
- e. How long have you been here?
- f. Level of education? Easiest ways for you to learn things?
- g. Results of a neuro check would be included in this category.

**7. Self Perception – Self Concept Pattern**

This pattern includes attitudes about self, perception of abilities, body image, identity, general sense of worth and emotional patterns.

- a. How would you describe your feelings about yourself?
- b. Have your health problems caused any changes in your body or the things that you can do? How have these changes affected the way you think about yourself?
- c. Do you have anxiety? How does it affect you?

**8. Role Relationship Pattern**

Describes client's perception of major roles and responsibilities in current life situation.

- a. How do your family and/or friends feel about your illness?
- b. How is your family managing now that you are here?
- c. Who comes to visit you here?
- d. What activities do you participate in here?
- e. Describe client's interactions with family members/significant others.

**9. Sexuality – Reproductive Pattern**

Describes client's satisfaction/dissatisfaction with sexuality; describes reproductive patterns.

- a. Any changes or problems in sexual relations?
- b. Use of contraceptives?
- c. Breast self-exam? Pap smears? Testicular self-exam? Pregnancy/menstrual history?

**10. Coping – Stress Tolerance Pattern**

Describes coping pattern and effectiveness of the pattern in terms of stress tolerance.

- a. What are the most significant changes in your life in the last year or two?
- b. What problems are you trying to deal with now? How do you handle them?
- c. When you are tense or upset, who is most helpful in talking things over? Is that person available to you now?
- d. Is client currently on any medication to assist him/her in coping?

**11. Value – Belief Pattern**

Describes patterns of values, beliefs including spiritual or other goals that guide choices or decisions.

- a. Have you generally gotten things that you wanted out of life?
- b. Is religion important in your life? Does this help when difficulties arise?
- c. Will being here interfere with your religious practices?

COMMUNITY COLLEGE OF RHODE ISLAND

NURS 1010 /1020

**NURSING CARE PLAN GUIDELINES**

1. State a **NANDA NURSING DIAGNOSIS** with etiology/risk factors in the first column. If the nursing diagnosis is an **ACTUAL** nursing diagnosis, specify the subjective and objective data validating the nursing diagnosis under **DEFINING CHARACTERISTICS**. **RISK** nursing diagnoses do not have defining characteristics.
2. In the second column, select an appropriate **NOC LABEL** for the nursing diagnosis specified. You may use a suggested NOC (Nursing Outcomes Classification) label (i.e., one suggested in the Ackley textbook) or one of your own choosing. Also state the related scale. To identify the related scale, refer to the handout “**NOC Outcome Labels and Related Measurement Scales**”. Most scales are constructed using a 1-5 rating with 5 reflecting the most desirable condition relative to the outcome. Note on the backside of the **CCRI NURSING CARE PLAN FORM – MEASUREMENT SCALES USED IN NOC**. Rate your patient’s status relative to the NOC outcome, as concluded from your initial assessment, and enter this Initial Rating, Date and Time in the space provided. In column two, also state a specific Client/Patient Outcome. Include a target date/time for achievement of the client/patient outcome . Remember that the client/patient outcome is derived from the problem statement, which is the first part of the nursing diagnosis. If achieved, it should demonstrate significant or complete resolution of the problem.
3. Proceed to column three. Select a suggested **NIC (NURSING INTERVENTIONS CLASSIFICATIONS) LABEL**, or one of your own choosing, that is appropriate for the stated **NOC LABEL AND PATIENT OUTCOME**. Determine and list interventions that are specific and individualized for your patient. Remember that nursing interventions are derived from the second part of the nursing diagnosis – specifically the etiology / risk factors, and therefore strive to deal with factors that cause or contribute to the problem.
4. In column four, specify **RATIONALES** for your nursing interventions.
5. Implement the Nursing Care Plan, i.e., carry out the individualized interventions.
6. Return to column two at the target date/time to complete evaluation of the Nursing Care Plan. Review the Client/Patient Outcome and (in collaboration with the patient, family, primary nurse - as appropriate) determine to what degree the outcome has been achieved (met, partially met, unmet). Review the Initial Rating on the NOC Scale and determine progression, if any, along the scale. In column two, specify an **END RATING & DATE/TIME** on the NOC scale and write an **EVALUATIVE STATEMENT** which describes outcome achievement and whether the plan should be continued, revised, etc.... If the plan is to be continued, state a subsequent evaluation date/time.
7. In column five, reflect on the experience of writing and implementing this Nursing Care Plan. Contemplate and please share your sense of accomplishment, learning, frustration and degree of satisfaction achieved during this process.

PB/rev.07/15/07



**MEASUREMENT SCALES USED IN NOC \***

<b>Scale</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
A	Severely compromised	Substantially compromised	Moderately compromised	Mildly compromised	Not compromised
B	Severe deviation from normal range	Substantial deviation from normal range	Moderate deviation from normal range	Mild deviation from normal range	No deviation from normal range
F	Not adequate	Slightly adequate	Moderately adequate	Substantially adequate	Totally adequate
G	10 and over	7-9	4-6	1-3	None
H	Extensive	Substantial	Moderate	Limited	None
I	None	Limited	Moderate	Substantial	Extensive
K	Never positive	Rarely positive	Sometimes positive	Often positive	Consistently positive
L	Very weak	Weak	Moderate	Strong	Very strong
M	Never demonstrated	Rarely demonstrated	Sometimes demonstrated	Often demonstrated	Consistently demonstrated
N	Severe	Substantial	Moderate	Mild	None
R	Poor	Fair	Good	Very good	Excellent
S	Not at all satisfied	Somewhat satisfied	Moderately satisfied	Very good	Excellent
T	Consistently demonstrated	Often demonstrated	Sometimes demonstrated	Rarely demonstrated	Never demonstrated

\* Johnson, M., & Maas, M. & Moorhead, S., (2004), Nursing Outcomes Classification (NOC), (3<sup>rd</sup> ed.), St. Louis: Mosby, p. 44-48

**NOC OUTCOMES LABELS  
AND RELATED MEASUREMENT SCALES \***

Abuse Cessation	I	Child Development: 6 months	M
Abuse Protection	F	Child Development: 12 months	M
Abuse Recovery: Emotional	I	Child Development: 2 years	M
Abuse Recovery: Financial	I	Child Development: 3 years	M
Abuse Recovery: Physical	I	Child Development: 4 years	M
Abuse Recovery: Sexual	I	Child Development: Preschool	M
Abuse Recovery Status	I	Child Development: Middle Childhood	M
Abusive Behavior Self-Restraint..	M	Child Development: Adolescence	M
Acceptance: Health Status	M	Circulation Status	A
Activity Tolerance	A	Client Satisfaction: Access to Care Resources	S
Adaptation to Physical Disability	M	Client Satisfaction: Caring	S
Adherence Behavior	M	Client Satisfaction: Communication	S
Aggression Self-Control	M	Client Satisfaction: Continuity of Care	S
Allergic Response: Localized	N	Client Satisfaction: Cultural Needs Fulfillment...	S
Allergic Response: Systemic	N	Client Satisfaction: Functional Assistance	S
Ambulation	A	Client Satisfaction: Physical Care	S
Ambulation: Wheelchair	A	Client Satisfaction: Physical Environment..	S
Anxiety Level	N	Client Satisfaction; Protection of Rights	S
Anxiety Self-Control	M	Client Satisfaction: Psychological Care	S
Appetite	A	Client Satisfaction: Safety	S
Aspiration Prevention	M	Client Satisfaction: Symptom Control	S
Asthma Self-Management	M	Client Satisfaction: Teaching	S
Balance	A	Client Satisfaction Technical Aspects of Care	S
Blood Coagulation	B	Cognition	A
Blood Glucose Level	B	Cognitive Orientation	A
Blood Loss Severity	N	Comfort Level	S
Blood Transfusion Reaction	N	Comfortable Death	A
Body Image	K	Communication	A
Body Mechanics Performance	M	Communication: Expressive	A
Body Positioning: Self-Initiated	A	Communication: Receptive	A
Bone Healing	I	Community Competence	R
Bowel Continence	M	Community Disaster Readiness	F
Bowel Elimination	A	Community Health Status	R
Breastfeeding Establishment: Infant	F	Community Health Status: Immunity	R
Breastfeeding Establishment: Maternal	F	Community Risk Control: Chronic Disease	R
Breastfeeding Maintenance	F	Community Risk Control: Communicable Disease	R
Breastfeeding Weaning	F	Community Risk Control: Lead Exposure	R
Cardiac Disease Self-Management..	M	Community Risk Control: Violence	R
Cardiac Pump Effectiveness	A	Community Violence Level	R
Caregiver Adaptation to Patient		Compliance Behavior	M
Institutionalization	M	Concentration	A
Caregiver Emotional health	A	Coordinated Movement	A
Caregiver Home Care Readiness	F	Coping	M
Caregiver Lifestyle Disruption	N	Decision Making	A
Caregiver-Patient Relationship	A	Depression Level	N
Caregiver Performance: Direct Care	F	Depression -Self Control	M
Caregiver Performance: Indirect Care	F	Diabetes Self-Management	M

Caregiver Physical Health	A
Caregiver Stressors	N
Caregiver Well-Being	S
Caregiving Endurance Potential	F
Child Adaptation to Hospitalization	M
Child Development: 1 month	M
Child Development: 2 months	M
Child Development: 4 months	M
Fall Prevention Behavior	M
Family Coping	M
Family Functioning	M
Family Health Status	A
Family Integrity	M
Family Normalization	M
Family Participation in Professional Care	M
Family Physical Environment	F
Family Resiliency	M
Family Social Climate	M
Family Support During Treatment	M
Fear Level	N
Fear Level: Child	N
Fear Self-Control	M
Fetal Status: Antepartum	B
Fetal Status: Intrapartum	B
Fluid Balance	A
Fluid Overload Severity	N
Grief Resolution	M
Growth	B
Health Beliefs	L
Health Beliefs: Perceived Ability to Perform	L
Health Beliefs: Perceived Control	L
Health Beliefs: Perceived Resources	L
Health Beliefs: Perceived Threat...	L
Health Orientation	L
Health-Promoting Behavior	M
Health-Seeking Behavior	M
Hearing Compensation Behavior...	M
Hemodialysis Access	A
Hope	M
Hydration	A
Hyperactivity Level	N
Identity	M
Immobility Consequences: Physiological	N
Immobility Consequences: Psychocognitive	N
Immune Hypersensitivity Response	N
Immune Status	A
Immunization Behavior	M
Impulse Self-Control	M
Infection Severity	N
Infection Severity: Newborn	N

Dignified Life Closure	M
Discharge Readiness: Independent Living	M
Discharge Readiness: Supported Living	M
Distorted Thought Self-Control	M
Electrolyte & Acid-Base Balance	A
Endurance	A
Energy Conservation	M
Falls Occurrence	G
Knowledge: Body Mechanics	I
Knowledge: Breastfeeding	I
Knowledge: Cardiac Disease Management	I
Knowledge: Child Physical Safety	I
Knowledge: Conception Prevention	I
Knowledge: Diabetes Management..	I
Knowledge: Diet	I
Knowledge: Disease Process	I
Knowledge: Energy Conservation	I
Knowledge: Fall Prevention	I
Knowledge: Fertility Promotion	I
Knowledge: Health Behavior	I
Knowledge: Health Promotion	I
Knowledge: Heath Resources	I
Knowledge: Illness Care	I
Knowledge: Infant Care	I
Knowledge: Infection Control	I
Knowledge: Labor and Delivery	I
Knowledge: Medication	I
Knowledge: Ostomy Care	I
Knowledge: Parenting	I
Knowledge: Personal Safety	I
Knowledge: Postpartum Maternal Health	I
Knowledge: Preconception Maternal Health	I
Knowledge: Pregnancy	I
Knowledge: Prescribed Activity	I
Knowledge: Sexual Functioning	I
Knowledge: Substance Use Control	I
Knowledge: Treatment Procedure(s)	I
Knowledge: Treatment Regimen	I
Leisure Participation	M
Loneliness Severity	N
Maternal Status: Antepartum	B
Maternal Status: Intrapartum	B
Maternal Status: Postpartum	B
Mechanical Ventilation Response: Adult	A
Mechanical Vent. Weaning Response: Adult...	A
Medication Response	A
Memory	A
Mobility	A
Mood Equilibrium	M

Information Processing	A
Joint Movement: Ankle	B
Joint Movement: Elbow	B
Joint Movement: Fingers	B
Joint Movement: Hip	B
Joint Movement: Knee	B
Joint Movement: Neck	B
Joint Movement: Passive	B
Joint Movement: Shoulder	B
Joint Movement: Spine	B
Joint Movement: Wrist..	B
Kidney Function	A
Newborn Adaptation	B
Nutritional Status	B
Nutritional Status: Food & Fluid Intake	F
Nutritional Status: Nutrient Intake	F
Oral Hygiene	A
Ostomy Self-Care	M
Pain: Adverse Psychological Response	N
Pain Control	M
Pain: Disruptive Effects	N
Pain Level	N
Parent-Infant Attachment	M
Parenting: Adolescent Physical Safety	M
Parenting: Early/Middle Childhood Phys. Safety	M
Parenting: Infant/Toddler Physical Safety	M
Parenting Performance	M
Parenting: Psychosocial Safety	M
Participation in Health Care Decisions	M
Personal Autonomy	M
Personal Health Status	A
Personal Safety Behavior	M
Personal Well-Being	S
Physical Aging	B
Physical Fitness	A
Physical Injury Severity	N
Physical Maturation: Female	B
Physical Maturation: Male	B
Play Participation	M
Postprocedure Recovery Status	B
Prenatal Health Behavior..	M
Preterm Infant Organization	A
Psychomotor Energy	M
Psychosocial Adjustment: Life Change	M
Quality of Life	S
Respiratory Status: Airway Patency	A
Respiratory Status: Gas Exchange	A
Respiratory Status: Ventilation	A
Rest	A
Risk Control	M

Motivation	M
Nausea and Vomiting Control	M
Nausea and Vomiting: Disruptive Effects	N
Nausea and Vomiting Severity	N
Neglect Cessation	I
Neglect Recovery	I
Neurological Status	A
Neurological Status: Autonomic	A
Neurological Status: Central Motor Control...	A
Neurological Status: Consciousness	A
Neurological Status: Cranial Sensory/Motor Func.	A
Neurological Status: Spinal Sensory/Motor Func.	A
Nutritional Status: Biochemical Measures	B
Nutritional Status: Energy	B
Self-Care: Non-Parenteral Medication	A
Self-Care: Oral Hygiene	A
Self-Care: Parenteral Medication	A
Self-Care: Toileting	A
Self-Care Status	A
Self Direction of Care	M
Self-Esteem	K
Self-Mutilation Restraint	M
Sensory Function: Cutaneous	B
Sensory Function: Hearing	B
Sensory Function: Proprioception	B
Sensory Function: Taste & Smell	B
Sensory Function: Vision	B
Sensory Function Status	B
Sexual Functioning	M
Sexual Identity	M
Skeletal Function	A
Sleep	A
Social Interaction Skills	M
Social Involvement.	M
Social Support	F
Spiritual Health	A
Stress Level	N
Student Health Status	A
Substance Addiction Consequences	N
Suffering Severity	N
Suicide Self-Restraint...	M
Swallowing Status	A
Swallowing Status: Esophageal Phase	A
Swallowing Status: Oral Phase	A
Swallowing Status: Pharyngeal Phase	A
Symptom Control	M
Symptom Severity	N
Symptom Severity: Perimenopause	N
Symptom Severity: Premenstrual Syndrome	N
Systemic Toxin Clearance: Dialysis	A

Risk Control: Alcohol Use	M	Thermoregulation	A
Risk Control: Cancer	M	Thermoregulation: Newborn	A
Risk Control: Cardiovascular Health	M	Tissue Integrity: Skin & Mucous Membranes	A
Risk control; Drug Use	M	Tissue Perfusion: Abdominal Organs	A
Risk Control: Hearing Impairment	M	Tissue Perfusion: Cardiac	A
Risk Control: Sexually Transmitted Diseases	M	Tissue Perfusion: Cerebral	A
Risk Control: Tobacco Use	M	Tissue Perfusion: Peripheral	A
Risk Control: Unintended Pregnancy	M	Tissue Perfusion: Pulmonary	A
Risk Control: Visual Impairment	M	Transfer Performance	A
Risk Detection	M	Treatment Behavior: Illness or Injury	M
Role Performance	F	Urinary Continence	M
Safe Home Environment	F	Urinary Elimination	A
Seizure Control	M	Vision Compensation Behavior	M
Self-Care: Activities of Daily Living (ADL)	A	Vital Signs	B
Self-Care: Bathing	A	Weight: Body Mass	B
Self-Care: Dressing	A	Weight Control	M
Self-Care: Eating	A	Will to Live	A
Self-Care: Hygiene	A	Wound Healing: Primary Intention	I
Self-Care: Instrumental ADL	A	Wound Healing: Secondary Intention	I

\* Adapted from Moorhead S, Johnson M, Maas ML., editors:  
*Nursing Outcomes Classification (NOC)*, ed 3, St. Louis, 2004, Mosby.

PAB/December 2005

COMMUNITY COLLEGE OF RHODE ISLAND

Patient Initials: LM  
 Medical Diagnosis: DVD - LLE

Student's Name: Steven Smith  
 Date: 4/14/07

NURSING CARE PLAN

NANDA NURSING DIAGNOSIS WITH ETIOLOGY/RISK FACTORS	NOC BASED PATIENT OUTCOME AND MEASUREMENT SCALE	NIC BASED INTERVENTIONS	RATIONALES	REFLECTION/SELF ASSESSMENT
<p>Hopelessness                      R/T prolonged activity restrictions and delayed recovery secondary to surgical procedure</p> <p><b>Defining Characteristics</b></p> <p><b>Subjective:</b>                      "I give up, I'm so sick and tired of this. I will never return to normal."</p> <p><b>Objective:</b>                      Pt. very agitated at times. Poor appetite &lt; 25% of meals consumed. BP 164/86.</p>	<p><b>NOC Label:</b> Hope</p> <p><b>Scale:</b> I</p> <p><b>Patient Outcome:</b>                      Will display hope for recovery and future by verbalizing feelings and making positive statements (i.e., I can/ I will try... by 4/14).</p> <hr/> <p><b>Initial Rating :</b>      <b>End Rating:</b>                      _____              _____                      2                              4</p> <p><b>Date:</b> <u>4/12</u>      <b>Date:</b> <u>4/14</u>  <b>Time:</b> <u>1600</u>      <b>Time:</b> <u>1300</u></p> <hr/> <p><b>Evaluative Statement:</b>                      Pt displayed a more positive attitude after speaking with MD following her surgical procedure. Although pt. was not able to attend granddaughter's wedding as planned they did visit her on that day, which brought her great happiness. Pt stated she is looking forward to returning home to plant flowers.</p>	<p><b>NIC Label(s):</b> Hope Installation</p> <p><b>Individualized Interventions:</b></p> <ol style="list-style-type: none"> <li>1. Spend one-on-one time with pt. use empathy, try to understand what the pt. is saying and communicate this to the pt.</li> <li>2. Assist pt. with setting goals that are important to her.</li> <li>3. Encourage expression of feelings and acknowledge acceptance of them.</li> <li>4. Use touch with permission to demonstrate caring.</li> <li>5. Use humor as appropriate.</li> <li>6. Express hope to pt. and give positive feedback whenever appropriate.</li> <li>7. Encourage visits from children.</li> <li>8. Encourage exercise of the mind to alleviate boredom—listening to the news or music relieves the monotony of hospitalization.</li> </ol>	<ol style="list-style-type: none"> <li>1. Experiencing warmth, empathy, genuineness, and unconditional positive regard can inspire hope. Empathy allows the nurse to communicate understanding without expressing feelings or judgment.</li> <li>2. Mutual goal setting ensures that goals are attainable and restores a sense of hope.</li> <li>3. A patient's ability to express negative emotions can be a healthy sign as strong emotions that are not expressed can be potentially dangerous.</li> <li>4. Human touch and presence may restore the human-centered dignity and affirmation of being that is necessary for the emergence of hope.</li> <li>5. Humor is an effective intervention for hopelessness.</li> <li>6. Sharing hope with a patient who is experiencing hopelessness was identified as helpful for redirecting thoughts.</li> <li>7. Children stimulate a sense of hope in many older adults.</li> <li>8. Focusing attention outside the self can decrease thoughts of hopelessness</li> </ol>	<p>With this patient I learned the importance of communication especially listening to the pt. and empathizing with her. I learned that just by sitting with her I encouraged to verbalize feelings that she otherwise would have kept to herself. Many of the nurses told me that this pt. was very difficult to deal with as she was agitated at times. I learned that her agitation was due to her frustration with her delayed recovery, which I felt was understandable. This learning experience will help me in the future when caring for other patients who have been labeled as "difficult". By listening to the pts. and encouraging verbalization to find the true reason for their irritability.</p>

RAC(03/03)

APPROVED: 05/16/02; 03/20/03; 8/15/07

Patient Initials: RK

Student's Name: Mary James

Medical Diagnosis: S/P Cholecystectomy

**NURSING CARE PLAN**

Date: 9/5/07

<p><b>NANDA NURSING DIAGNOSIS WITH ETIOLOGY/RISK FACTORS</b></p>	<p><b>NOC BASED PATIENT OUTCOME AND MEASUREMENT SCALE</b></p>	<p><b>NIC BASED INTERVENTIONS</b></p>	<p><b>RATIONALES</b></p>	<p><b>REFLECTION/ SELF ASSESSMENT</b></p>
<p>Risk for ineffective breathing pattern r.t. anesthesia, immobility, lack of deep breathing 2<sup>0</sup> to location of incision</p> <p><b><u>Defining Characteristics</u></b></p> <p><b><u>Subjective:</u></b></p> <p>“I’ve been quite tired and can fall asleep at the drop of a hat” “It hurts my incision when I take a deep breath.”</p> <p><b><u>Objective:</u></b></p> <p>Diminished breath sounds and weak cough when in bed.</p> <p>Pt. was placed on bedrest for 48 hrs. post-op.</p>	<p><b><u>NOC Label:</u></b></p> <p>Respiratory Status: Ventilation</p> <p><b><u>Scale:</u></b> A</p> <p><b><u>Patient Outcome:</u></b></p> <p>Pt. will have clear breath sounds and a respiratory rate of 16 - 20/min.</p> <hr/> <p><b><u>Initial Rating :</u></b>      <b><u>End Rating:</u></b></p> <p>      <u>4</u>                      <u>5</u></p> <p><b><u>Date:</u></b> <u>9/04</u>      <b><u>Date:</u></b> <u>9/05</u></p> <p><b><u>Time:</u></b> <u>1900</u>      <b><u>Time:</u></b> <u>1300</u></p> <hr/> <p><b><u>Evaluative Statement:</u></b></p> <p>Pt.’s level of ventilation vastly improved when in high fowler’s or standing positions. Mobility was shown to increase ventilation (as was demonstrated on Incentive Spirometer) and increased productivity and strength of cough</p>	<p><b><u>NIC Label(s):</u></b></p> <p>Respiratory Monitoring Airway Management</p> <p><b><u>Individualized Interventions:</u></b></p> <ol style="list-style-type: none"> <li>Respiratory Assessment q 4<sup>o</sup> : <ul style="list-style-type: none"> <li>√ VS</li> <li>√ lung sounds</li> <li>√ for cough ( prod. or unprod.)</li> <li>√ for signs of hypoxia, dyspnea and SOB</li> </ul> </li> <li>Turn, cough and deep breathe q 1<sup>o</sup></li> <li>Incentive Spirometer x 2 q 1<sup>o</sup> HOB in High Fowler Position</li> <li>OOB with 1 assist to ambulate as tolerated and sit up in chair for at least 45 min. TID</li> <li>Monitor for pain and comfort as needed</li> </ol>	<ol style="list-style-type: none"> <li>Normal resp. rate for a healthy adult is 12 – 20/min. Abnormal breath sounds (diminished sounds, crackles, wheezes) can indicate a resp. complication (pneumonia, hypoventilation). A weak cough may indicate an inability to clear the airway of secretions, increase risk for stagnation of secretions.</li> <li>Turning , coughing and deep breathing will promote lung expansion to improve oxygenation and mobilize secretions for expectoration.</li> <li>I. S. encourages pt. to execute and sustain maximum inspiration which will open airways and stimulate coughing.</li> <li>Ambulation stimulates respiration by ↑ metabolic need and places pt. in optimal physiological position to breathe deeply. Max. chest expansion is possible and ventilation /perfusion ratio is optimal in upright position.</li> <li>The location of the incision for a cholecystectomy is close to the diaphragm. Thus, acute pain in this location will contribute to hypoventilation. Good pain control will enable the patient to take deeper breaths.</li> </ol>	<p>I really appreciated caring for this patient and seeing how important mobility is for a post-op patient. Although it took a lot of effort to get her up and moving, the benefits were clearly seen in her respiratory status and general health perception.</p>

COMMUNITY COLLEGE OF RHODE ISLAND

NURS 1010 /1020

CRITERIA FOR EVALUATION OF NURSING CARE PLAN

Name \_\_\_\_\_ Date \_\_\_\_\_

**Patient Initials** \_\_\_\_\_ **Diagnosis** \_\_\_\_\_

Nursing Care Plan Components	Meets Criteria	Criteria Not Met/Revisions Needed
<b>Nursing Diagnosis:</b> <ul style="list-style-type: none"> <li>• Is an approved NANDA diagnosis?</li> </ul>		
<b>“Related to”</b> statement: <ul style="list-style-type: none"> <li>• Does it identify etiology, contributing factor or risk factor for nursing diagnosis?</li> </ul>		
<b>“Defining Characteristics”</b> : <ul style="list-style-type: none"> <li>• Does the subjective and/or objective data validate the nursing diagnosis?</li> </ul>		
<b>NOC Label:</b> <ul style="list-style-type: none"> <li>• Is <b>NOC Label</b> appropriate for nursing diagnosis?</li> </ul>		
<ul style="list-style-type: none"> <li>• Is measurement <b>Scale</b> appropriate for <b>NOC</b> label?</li> </ul>		
<b>Patient Outcome</b> <ul style="list-style-type: none"> <li>• Does <b>patient outcome</b> identify the <b>client behavior</b> that the nurse expects to occur, is it stated in <b>measurable terms</b>, is there a <b>date/time</b> to achieve goal?</li> </ul>		
<ul style="list-style-type: none"> <li>• Does <b>Initial Rating status &amp; date &amp; time</b> reflect the client status relative to the outcome?</li> </ul>		
<ul style="list-style-type: none"> <li>• Does <b>End Rating status &amp; date &amp; time</b> reflect what degree outcome was met by the patient?</li> </ul>		

Care Plan Components	Meets Criteria	Revisions Needed
<p><b>Evaluative Statement</b></p> <ul style="list-style-type: none"> <li>Does <b>Evaluative Statement</b> describes outcome achievement, and if care plan is to be continued, revised, discontinued?</li> </ul>		
<p><b>NIC Label</b></p> <ul style="list-style-type: none"> <li>Is the <b>NIC Label</b> appropriate for the stated NOC label and patient outcome?</li> </ul>		
<ul style="list-style-type: none"> <li>Are <b>NIC Based Interventions</b> listed according to the intended sequence of nursing actions? Is each nursing action listed by a number to reflect the sequence of action?</li> </ul>		
<ul style="list-style-type: none"> <li>Are <b>NIC Based Interventions</b> specific and individualized for your patient? Do they identify the timing and frequency of nursing interventions, i.e., every 2 hours, QID?</li> </ul>		
<ul style="list-style-type: none"> <li>Are all appropriate <b>NIC Based Interventions</b> identified or are more needed?</li> </ul>		
<ul style="list-style-type: none"> <li>Are <b>Rationales</b> listed and numbered so as to correspond to each numbered nursing intervention?</li> </ul>		
<ul style="list-style-type: none"> <li>Do <b>Rationales</b> reflect the scientific principles behind each nursing intervention?</li> </ul>		
<p><b>Reflection/Self Assessment</b></p> <ul style="list-style-type: none"> <li>Does statement reflect on the student's experience of writing this care plan?</li> </ul>		
<ul style="list-style-type: none"> <li>Is statement missing or not reflective of student's experience (more patient centered)?</li> </ul>		

8/07

Additional Comments:

## **APPENDIX A**

Preliminary Data Sheet

Nursing Assessment Form

Criteria for Evaluation of Nursing Assessment Form

**COMMUNITY COLLEGE OF RHODE ISLAND  
NURSING PROGRAM  
PRELIMINARY DATA SHEET FOR CLINICAL ASSIGNMENTS**

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Room # \_\_\_\_\_ Patient (initials) \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Residence: Home \_\_\_\_\_ Other (specify) \_\_\_\_\_

Reason for Admission: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

Medical Diagnoses: (definitions of each to be attached to this sheet) \_\_\_\_\_

Surgery: (definition to be attached to this sheet) \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Concurrent Medical Problems: \_\_\_\_\_

Allergies: \_\_\_\_\_ Code Status: \_\_\_\_\_

**NURSING CARE:**

Diet (purpose) \_\_\_\_\_

IV (purpose, solution, rate) \_\_\_\_\_

I & O:     yes     no    VS (how often) \_\_\_\_\_    Activity Order: \_\_\_\_\_

Additional Nursing Actions (wound care, foley care, O<sub>2</sub> therapy, safety precautions, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: (attach medication sheet)

Diagnostic Tests/Consults: (attach diagnostic tests sheet)

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**FOCUSED ASSESSMENT**

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**PLANNED NURSING ACTIONS**

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**ANTICIPATED LEARNING NEEDS/PATIENT EDUCATION**

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_ STUDENT: \_\_\_\_\_

MEDICATION	DOSE	TIME	ROUTE	REASON GIVEN	NURSING MEASURES	MAJOR SIDE EFFECTS	SPECIAL CONSIDERATIONS

PATIENT: \_\_\_\_\_

**DIAGNOSTIC TESTS/CONSULTS**

DIAGNOSTIC TEST	DATE	NORMAL	PATIENT RESULTS	NURSING SIGNIFICANCE

**CONSULTATIONS: (List type, date and results if available)**

**COMMUNITY COLLEGE OF RHODE ISLAND  
NURSING ASSESSMENT FORM**

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Patient (Initials): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Adm. Date: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

Allergies: \_\_\_\_\_ Code Status: \_\_\_\_\_

**FUNCTIONAL HEALTH PATTERNS**

**NURSING DIAGNOSIS**

<p><b>1. <u>Health Perception/Health Maintenance Pattern</u></b></p> <p>Patient Perception of General Health _____</p> <p>Health Practices _____</p> <p>Ability/Willingness to Participate in Care _____</p> <p>Smoking/Tobacco/Alcohol/Drug History _____</p>	
<p><b>2. <u>Nutrition/Metabolic Pattern</u></b></p> <p>Diet: _____ Purpose: _____</p> <p>Appetite _____ % of food eaten at mealtime _____</p> <p>Fluid intake in 24 hrs. _____ IV type, rate, amt. _____</p> <p>Nausea _____ Vomiting _____</p> <p>Weight loss/gain (amt.) _____ Food Intolerances _____</p> <p>Dentures: _____</p> <p>Skin Integrity: dryness, skin turgor, decubiti, bruises, reddened, incision (describe) _____</p>	
<p><b>3. <u>Elimination Pattern</u></b></p> <p>Bowel Patterns _____ Date of Last BM: _____</p> <p>Constipation: _____ Diarrhea: _____ Ostomy (type): _____</p> <p>Abdomen: soft, hard, distended _____ Bowel Sounds: _____</p> <p>Bladder Patterns: _____ Urine Output/24 hrs.: _____</p> <p>Urine (describe color &amp; clarity): _____</p> <p>Foley: _____ Intermittent Catheterization: _____ Incontinent Briefs: _____</p>	

**FUNCTIONAL HEALTH PATTERNS**

**NURSING DIAGNOSIS**

<p><b>4. <u>Activity/Exercise Pattern (self-care ability)</u></b></p> <p>0 = Independent          1 = Assistive Devices          2 = Assistance from others          3 = Assistance from person and equipment          4 = Dependent/Unable</p> <p>Eating: _____ Dressing/Grooming: _____ Bathing: _____ Bed Mobility: _____          Transferring: _____ Ambulating: _____ Drinking: _____ Toileting: _____          Assistive Devices: None _____ Crutches _____ Walker _____          Bedside Commode _____ Other _____</p>	
<p><b><u>Activity/Exercise Pattern (mobility)</u></b></p> <p>Range of Motion: Full _____ Other _____          Balance &amp; Gait: Steady _____ Unsteady: _____          Hand Grasp: Equal _____ Strong _____          Weakness/Paralysis: Right _____ Left _____          Leg Muscles: Equal _____ Strong _____          Weakness/Paralysis: Right _____ Left _____          Number of people needed to assist with ambulation: _____</p>	
<p><b><u>Activity/Exercise Pattern (respiratory/circulatory status)</u></b></p> <p>Baseline Vital Signs: T _____ P _____ R _____ BP _____          Current Vital Signs: T _____ P _____ R _____ BP _____          Resp. Quality: Dyspnea <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> SOB <input type="checkbox"/> Use of Accessory Muscles          Resp. Pattern: <input type="checkbox"/> Eupnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Cheyne-Stokes          Breath Sounds: <input type="checkbox"/> Clear <input type="checkbox"/> Abnormal (describe): _____          C/O pain with Resp.: <input type="checkbox"/> yes <input type="checkbox"/> no          Oxygen Therapy: _____ SaO<sub>2</sub> _____          Cough <input type="checkbox"/> yes <input type="checkbox"/> no          Sputum <input type="checkbox"/> yes <input type="checkbox"/> no color: _____          Clubbing <input type="checkbox"/> yes <input type="checkbox"/> no          Facial Color <input type="checkbox"/> pale <input type="checkbox"/> pink <input type="checkbox"/> cyanotic <input type="checkbox"/> other (describe): _____          Facial Skin <input type="checkbox"/> warm <input type="checkbox"/> cool <input type="checkbox"/> dry <input type="checkbox"/> moist          Extremities <input type="checkbox"/> warm <input type="checkbox"/> cool color (describe): _____          Edema <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> pitting (location): _____          CRT (lower) &lt;3 sec. <input type="checkbox"/> yes <input type="checkbox"/> no CRT (upper) &lt;3 sec. <input type="checkbox"/> yes <input type="checkbox"/> no          Homan's Sign _____          JVD _____          Peripheral Pulses: Radial Pulse _____ Pedal Pulse _____          Apical Pulse Rate: _____ regular _____ irregular _____          Heart Sounds: _____</p>	
<p><b>5. <u>Sleep/Rest Patterns</u></b></p> <p>Usual Hours of Sleep: _____ Last Night (hrs): _____          Naps _____ Insomnia _____ Sleep Aids _____          Generally rested and ready for daily activities after sleep? _____</p>	



**FUNCTIONAL HEALTH PATTERNS**

**NURSING DIAGNOSIS**

<p><b>10. <u>Coping/Stress Tolerance Pattern</u></b></p> <p>Major loss/change in the past year?</p> <p>What problem/s is the patient trying to deal with now?</p> <p>How does the patient usually deal with these situations?</p> <p>Emotional state of patient:</p> <p>Is patient on any medications to assist in coping?</p>	
<p><b>11. <u>Value/Belief Pattern</u></b></p> <p>Religious or spiritual beliefs which help to give the patient inner strength?</p> <p>Religious/spiritual/cultural practices during hospitalization?</p>	

**NOTE: Prioritize the top three Nursing Diagnoses according to Maslow's Hierarchy of Needs.**

<p><b>ADDITIONAL ASSESSMENT</b></p>	<p align="center"><b>LEARNING NEEDS</b></p>
<p><b>DISCHARGE PLANNING</b></p> <p>Lives:    <input type="checkbox"/> Alone    <input type="checkbox"/> With Family    <input type="checkbox"/> Nursing Home    <input type="checkbox"/> Other</p> <p>Destination Post Discharge: <input type="checkbox"/> Home    <input type="checkbox"/> Nursing Home    <input type="checkbox"/> Other</p> <p>Support Systems upon Discharge:</p> <p>Previous Use of Community Resources:</p> <p>Needs assistance with one or more of the following: food preparation, wound care, meds, shopping, supplies, ambulation, transportation, other (specify):</p> <p>Community Resources Needed:</p>	

**COMMUNITY COLLEGE OF RHODE ISLAND**

**NURS 1010 /1020**

**CRITERIA FOR EVALUATION OF NURSING ASSESSMENT FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Patient Initials** \_\_\_\_\_ **Diagnosis** \_\_\_\_\_

<b>Nursing Assessment Components</b>	<b>Meets Criteria</b>	<b>Criteria Not Met/Revisions Needed</b>
<p><b>Assessment Data:</b></p> <ul style="list-style-type: none"> <li>• All assessment questions have been answered. There is no missing data. There are no blank spaces.</li> <li>• Data obtained is sufficient.</li> <li>• Data obtained is accurate.</li> </ul>		
<p><b>Nursing Diagnosis:</b></p> <ul style="list-style-type: none"> <li>• Is based on the patient data obtained and documented in the assessment form.</li> <li>• Is written whenever a problem area is identified in each functional patterns.</li> <li>• Is an approved NANDA diagnosis?</li> <li>• Is an accurate statement of the problem area.</li> </ul>		
<p><b>“Related to” statement:</b></p> <ul style="list-style-type: none"> <li>• Does it identify etiology, contributing factor or risk factor for nursing diagnosis?</li> </ul>		
<p><b>Prioritizes the Top 3 Nursing Diagnosis</b></p>		

Additional Comments:

HHJ 8/07