NURSING CARE PLAN

Nursing Diagnosis: Risk for impaired skin integrity related to abdominal incision as evidenced by abdominal aortic aneurysm repair.

Supporting Data	Desired Outcomes	Interventions	Rationale	Evaluation
Subjective "The doctor said I will need to make sure my incisions do not get infected. With all of my health issues I do not want to cause anymore problems." **Objective** After assessment of the patient and her laboratory values, with increased white blood cells, chronic renal failure, and extensive health history, her risk for infection is heightened, and must be watched closely, with preventative measures taken.	**Short-Term Desired Outcomes** The patient will demonstrate understanding of self-care activities by the end of the first post-op day. **Long-Term Desired Outcomes** The patient will identify possible danger signs of infection to take note of and notify the physician with before discharge.	1. The RN will "inspect the incision every shift and document findings"(Ralph & Taylor, 2008). 2. The RN will "instruct and assist the patient with general hygiene, including hand-washing and toileting practices" (Ralph & Taylor, 2008). 3. The RN will "inform the patient of the purpose of self-care practices" (Ralph & Taylor, 2008). 1. The RN will "perform the prescribed treatment regimen. The RN will monitor progress and report favorable and adverse responses" (Ralph & Taylor, 2008). 2. The RN will "instruct the patient and partner in the possible danger signs and symptoms that should be reported to the physician immediately" (Ralph & Taylor, 2008). 3. The RN will have the patient state what items they will report, being fever of 100.4 on two readings, incisional drainage, or reddened, warm skin around incision.	1. "Frequent assessment can detect signs and symptoms of possible infection" (Ralph & Taylor, 2008). 2. "Proper handwashing is the most effective method of disease prevention"(Ralph & Taylor, 2008). 3. "To increase compliance" (Ralph & Taylor, 2008). 1. "Periodic cleaning decreases bacterial concentrations, thus aiding in the healing process. Monitoring response to treatment can help identify a possible need for alternative interventions" (Ralph & Taylor, 2008). 2. "Prompt reporting of danger signs and symptoms may help prevent major complications" (Ralph & Taylor, 2008). 3. "Prompt reporting of danger signs and symptoms may help prevent major complications" (Ralph & Taylor, 2008).	**Short-Term Desired Outcome:** The patient demonstrated understanding of self-care activities by the end of the first post-op day. Goal Met. Nursing Interventions for this goal were effective for attainment of the goal. **Long-Term Desired Outcome:** The patient was able to identify possible danger signs of infection to take note of and could state when to notify the physician on the second post-op day. Goal Met. Nursing interventions for this goal were effective and allowed the patient to achieve the long-term goal.

NURSING CARE PLAN

Nursing Diagnosis: Activity intolerance related to imbalance between oxygen supply and demand as evidenced by shortness of breath and fatigue with minimal activity tolerance.

Supporting Data	Desired Outcomes	Interventions	Rationale	Evaluation
Subjective "I'm just so tired. Moving around just takes my breath away. I am so short of breath." **Objective** The patient appears fatigued and her breathing appears to be labored after moving in bed or getting up out of bed. She is diagnosed with COPD and is prescribed corticosteroids for her disease.	**Short-Term Desired Outcomes** The "patient will state understanding of the need to increase activity level gradually" (Ralph & Taylor, 2008) within 12 hours. **Long-Term Desired Outcomes** The "patient will explain illness (COPD) and connect symptoms of activity intolerance with deficit in oxygen supply or use" (Ralph & Taylor, 2008) before discharge.	1.The RN will "encourage patient to help plan activity progression, being sure to include activities she considers essential(Ralph & Taylor, 2008). 2.The RN will "instruct and help patient to alternate periods of rest and activity" (Ralph & Taylor, 2008). 3. The RN will "teach patient how to conserve energy while performing ADL's" (Ralph & Taylor, 2008). 1.The RN will "monitor physiologic responses to increased activity and document the time after each period of exercise"(Ralph & Taylor, 2008). 2.The RN will "identify activities patient considers desirable and meaningful" (Ralph & Taylor, 2008). 3. The RN will help the patient list signs of fatigue and what to do when signs are felt. She will formulate a plan to enable the patient to continue functioning as much as possible.	1. "Participation in planning may encourage patient compliance with the plan" (Ralph & Taylor, 2008). 2. "Providing rest periods prevents fatigue and encourages patient to continue improving activity tolerance" (Ralph & Taylor, 2008). 3. This will "reduce cellular metabolism and oxygen demand" (Ralph & Taylor, 2008). 1. "Values should return to normal within five minutes or less" (Ralph & Taylor, 2008). 2. "Engaging patient in activities that have personal meaning may motivate patient to continue developing tolerance" (Ralph & Taylor, 2008). 3. This will "help foster patient's independence" (Ralph & Taylor, 2008).	**Short-Term Desired Outcomes** The patient is able to state and acknowledges that she needs to gradually increase her activity level within 8 hours. Goal Met. Nursing interventions for this goal were effective to help the patient acknowledge gradual activity. **Long-Term Desired Outcomes** The patient is able to explain her illness (COPD) and connect symptoms of activity intolerance because of deficient oxygen supply. Nursing interventions for this goal were effective to help the patient explain her illness.