Nursing Care Plan

- A nursing care plan outlines the nursing care to be provided to a patient.
- It is a set of actions the nurse will implement to resolve nursing problems identified by assessment.
- The creation of the plan is an intermediate stage of the nursing process.
- Nursing process is a patient centered, goal oriented method of caring that provides a framework to nursing care.

Nursing care plan involves 5 major steps:

- A – Assess (What is the situation?)
- D – Diagnose (What is the problem?)
- P – Plan (How to fix the problem.)
- I – Implementation/intervention (Putting the plan into action.)
- E – Evaluation (Did the plan work?)

ADPIE

Characteristics of the nursing care plan

1. It focuses on actions which are designed to solve or minimize the existing problem.
2. It is a product of a deliberate systematic process.
3. It relates to the future.
4. It is based upon identifiable health and nursing problems.
5. Its focus is holistic.
6. It focuses to meet all the needs of the individual.

Elements of the plan

- In the USA, the nursing care plan consist of related factors and subjective and objective data that support the diagnosis, nursing outcome classifications with specified outcomes (*goals*) to be achieved including deadlines, and nursing intervention classifications with specified interventions.

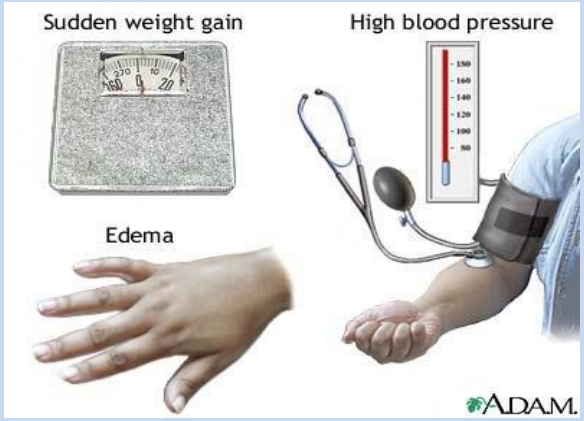
http://www1.us.elsevierhealth.com/MERLIN/Gulanick/Constructor/

The Nursing Process

First – the nurse collects subjective and objective data

How to collect data:

- Client interview
- Physical Examination
- Observation



Second – the nurse makes a *nursing diagnosis*

A nursing diagnosis is a *clinical judgment* about:

- Individual, family, or community experiences
- Responses to actual or potential health problems

  or

- Life processes

Nursing diagnoses are developed based on data obtained during the nursing assessment.

For example, a nurse may give the following diagnosis to a patient with pneumonia that has difficulty breathing:

- Ineffective Airway Clearance related to tracheobronchial infection (pneumonia) and excess thick secretions as evidenced by abnormal breath sounds; crackles, wheezes; change in rate and depth of respiration; and effective cough with sputum. (This Nursing Diagnosis is taken from the list of NANDA's functional health patterns, Disturbed pattern is "Activity and Exercise pattern")

Components of a nursing diagnosis

- Problem Statement (diagnostic label): describes the patient's health problem
- Etiology (related factor): the probable cause of the health problem
- Defining Characteristics: a cluster of signs and symptoms; ex: *Ineffective airway clearance related to the presence of tracheo-bronchial secretion as manifested by thick tenacious sputum upon expectoration.*

Problem (Ineffective airway clearance)

+

Etiology (related to)

+

Defining Characteristics (as manifested by)

Third – the nurse must state the expected outcomes, or goals.

- A common method of formulating the expected outcomes is to reverse the nursing diagnosis, stating what evidence should be present in the absence of the problem.
- The expected outcomes must be measurable and also contain a goal date.
- Following the previous example on pneumonia, the expected outcome would be: *Effective airway clearance as evidenced by normal breath sounds; no crackles or wheezes; respiration rate 14-18 min; and no cough by 01/01/01.*

Fourth – the nursing implementation/ interventions must be established.

- This is the methods by which the goal will be achieved.
- The methods of implementation/intervention must be recorded in an explicit and tangible format in a way that the patient can understand should he or she wish to read it.
- Clarity is essential as it will aid communication between those tasked with carrying out patient care.
- The interventions must be specific, noting how often it is to be performed, so that any nurse or appropriate faculty can read and understand the care plan easily and follow the directions exactly.
- An example for the previous patient would be: Instruct and assist client to TCDB (turn, cough, deep breathe) to assist in loosening and expectoration of mucous every 2 hours.

Fifth – the evaluation is made on the goal date set.

- It is stated whether or not the client has met the goal, the evidence of whether or not the goal was met, and if the care plan is to be continued, discontinued or modified. If the care plan is problem-based and the client has recovered, the plan would be discontinued. If the client has not recovered, or if the care plan was written for a chronic illness or ongoing problem, it may be continued. If certain interventions are not helping or other interventions are to be added, the care plan is modified and continued.

The multidisciplinary care team at Sitrin meets twice weekly to assess patient progress. The team consists of a physiatrist, case manager, occupational therapist, physical therapist, dietary technician, recreational therapist, speech-language pathologist, medicare coordinator, and members of the nursing team.