Care Plan Corner

Instructions

Use the blank care plan at the bottom of the page to create your own plan.

Altered/Alterations	*Impaired/Impairment*	*General*
Bowel Elimination: Constipation	Adjustment	Activity Intolerance
Bowel Elimination: Diarrhea	Gas Exchange	Anxiety
Cardiac Output: Decreased	Home Maintenance Management	Coping: Ineffective Individual
Comfort: Chest Pain	Physical Mobility	Discharge
Comfort: Pain	Skin Integrity	Disuse Syndrome
Family Processes	Social Interaction	Diversional Activity Deficit
Growth and Development	Verbal Communication	Fear
Health Maintenance		Fluid Volume Deficit
Nutrition: Less than Body Requirements		Fluid Volume Excess
Nutrition: More than Body		Grieving
		Hyperthermia
		Hypothermia

Requirements

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Parenting

Sensory Perceptual

Sexuality Patterns

Thought Process

Urinary Elimination: Incontinence

Urinary Elimination: Retention

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Ineffective Airway Clearance

Ineffective Breathing Patterns

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Powerlessness

Rape Trauma Syndrome

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blank plan

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Fran Beall, RN, CS, ANP

WebWizard/ Technical -
MSB

Careplan Corner @ RN Central

Are you a student in need of some ideas for your care plans? Are you required to use standardized care plans at work and need some ideas? If you answered yes then this is the place for you! These are only *suggested*, pre-defined care plans. You may copy, save, print and modify them in any way you wish. If you have any suggestions for additions, please contact RN Central!

When you click on the links to the care plans , they will show up in a new window.

To print out the care plans:

Internet Explorer:
Right click inside the frame you want to print. Choose *"print"* from the pop up menu.

Netscape:
Click somewhere inside the frame you want to print. Go to *"File"* on your browser's top menu, select *"Print Frame"*.

After printing your plan, close the new window.

Alteration in Bowel Elimination: Constipation

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Malnutrition (_) Metabolic and endocrine disorders (_) Sensory/motor disorders (_) Stress (_) Immobility (_) Inadequate diet (_) Irregular evacuation pattern	(_) Drug side effects (_) Pain (upon defecation) (_) Pregnancy (_) Surgery (_) Lack of privacy (_) Dehydration (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Hard formed stool and/or defecation occurs fewer than three times per week.
Minor: (*May be present*)	(_) Decreased bowel sounds. (_) Reported feeling of rectal fullness or pressure around rectum. (_) Straining and pain on defecation. (_) Palpable impaction.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions [*[Check those that apply]*	Date Achieved:

	The patient will: (_) Have soft formed stool by _____ and q ___ day(s). (_) Patient and/or significant other will verbalize an understanding of method for preventing and/or treating constipation.		(_) Assess abdomen for distention, bowel sounds q ___ hours. (_) Assess bowel elimination q ___ hours. (_) Asses factors responsible for constipation: • stress • discomfort • sedentary lifestyle • laxative abuse • debilitation • lack of time/privacy • drug side effect (_) Promote corrective measures: • review daily routine • provide privacy/time • provide comfort • encourage adequate exercise (_) Promote adequate dietary/ fluid intake. Patient likes: Fluids:_____ _____ Fiber foods:_____ _____ (_) Initiate bowel program to promote defecation. (_) Consult dietitian. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Bowel Elimination: Diarrhea

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Inflammation of bowels (_) Colon mucosa ulceration (_) Fecal impaction (_) Gastric bypass (_) Infant - breast fed (_) Decreased sphincter reflexes (_) Allergies	(_) Medications_____ _____ (_) Stress/anxiety (_) Tube feedings (_) Decreased tolerance to dietary program: _____ _____ (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Loose liquid stools and/or: (_) Frequency
Minor: (*May be present*)	(_) Urgency (_) Cramping/abdominal pain (_) Hyperactive bowel sounds (_) Increase of fluidity or volume of stools

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Have stool/elimination pattern that closer resembles that of patient's normal stool/pattern. (_) Patient and/or significant other will verbalize methods for preventing and/or treating diarrhea. (_) Other:		(_) Assess abdomen for distention, bowel sounds, pain q___ hours. (_) Identify factors that contribute to diarrhea:_____ _____ _____ _____ (_) Record color, odor, amount and frequency of stool. (_) Instruct patient in: • diet • medication usage • S/S of diarrhea to watch for requiring medical attention • discontinuing solids • offer clear liquids. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alterations in Cardiac Output: Decreased

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Cardiac factors	(_) Vagal stimulation
(_) Pulmonary disorders	(_) Stress
(_) Endocrine disorders	(_) Shock
(_) Hematological disorders	(_) Allergic response
(_) Fluid & electrolyte disturbances	(_) Medications
(_) Surgery/anesthesia	(_) Other:_____
(_) Newborn/Infant	_____
	_____

As evidenced by:

[Check those that apply]

(_) Angina	(_) Fatigability
(_) Cardiac arrythmia	(_) Hypotention
(_) Cyanosis	(_) Oliguria
(_) Dyspnea	(_) Restlessness
(_) Edema (periph./sacral)	(_) Tachycardia

Date & Sign.	**Plan and Outcome** *[Check those that apply]*	**Target Date:**	**Nursing Interventions** *[Check those that apply]*	**Date Achieved:**

	The patient will: (_) Demonstrate imporved cardiac output A.E.B.: • vital signs within normal limits for patient. [BP____] [P___] • color pink • chest clear • balanced I & O • minimal or absent edema (_) Other:		(_) Assess color, BP, pulse, respirations q___ hours. (_) Listen to breath sounds q___ hours. (_) Check for edema of feet, legs, and sacrum q___ hours. (_) Daily weights at ____ a.m./p. m. using same scale. (_) Measure intake and output q 8 hours. (_) Organize care to maximize periods of uninterrupted rest. Needs _____ rest periods/day. (Specify:): _____ (_) Explore with patient potential etiological factors for decreased cardiac output and provide health teaching. (See Discharge Plan) (_) Other:_____ _____ _____ _____ (_) Discharge Plan:_____ _____ _____ _____	

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Patient/Significant other signature

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Comfort: Chest Pain

Related To:

[Check those that apply]

(_) Myocardial Infarction (_) Unstable Angina (_) Coronary Artery Disease (_) Chest Trauma (_) Stress Anxiety	(_) Musculoskeletal Disorders (_) Pulmonary, Myocardial contusion (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Person reports or demonstrates a discomfort.
Minor: (*May be present*)	(_) Increased BP (_) Diaphoresis (_) Dilated pupils (_) Restlessness (_) Facial mask of pain (_) Crying/moaning (_) Short of breath (_) Anxiety

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Verbalize relief/control of pain. (_) Verbalize causative factors associated with chest pain. (_) Other:		(_) Assess for causative factors asssociated: • Activity • Stress • Eating • Bowel elimination • Previous angina attack • Other: (_) Assess characteristing of chest pain. • Location • Intensity (Scale 1-10)	

- Duration
- Quality
- Radiation

(_) Review history of previous pain experienced by patient and compare to current experience.

(_) Instruct patient to report pain immediately.

(_) Continuous EKG monitoring; note and record pattern during pain. Obtain STAT 12-lead EKG per policy for acute changes noted on continuous monitor.

(_) Provide a quiet, restful environment.

(_) As per physician order, administer IV analgesics in small increments until pain is relieved or maximum dose is achieved. Monitor BP during administration of pain meds. Assess pt. response to pain medication and notify physician if pain is not controlled or pt. experiences adverse reaction (decreased BP, HA, distress).

(_) Administer nitroglycerine as ordered by physician. Monitor as stated above.

(_) Titrate IV Nitro to achieve pain relief as ordered by physician. Monitor hemodynamic response to medication (BP, urine output).

(_) Administer supplemental oxygen as ordered by physician.

			(_) Assist with ADL's to reduce cardiac stressors. (_) Assist in eliminating causative factors as identified by patient assessment. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Comfort: Pain

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Musculoskeletal disorder (_) Visceral disorder (_) Cancer (_) Information (_) Trauma (_) Diagnostic test	(_) Immobility/improper positioning (_) Pressure points (_) Pregnancy (_) Fear (_) Anxiety/stress (_) Overactivity (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Pt. reports or demonstrates discomfort.
Minor: (*May be present*)	(_) Autonomic response to acute pain: • increased BP, P, R • diaphoresis • dilated pupils • guarding • facial mask of pain • crying/moaning • abdominal heaviness • cutaneous irritation

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Experience relief of pain A.E. B. • verbal reports of relief of pain • less autonomic responses to pain (_) Other:		(_) Asses characteristics of pain: location, severity on a scale of 1-10, type, frequency, precipitating factors, relief factors. (_) Eliminate factors that precipitate pain: eg.: _____ _____ (_) Offer analgesics q___ hrs prn (according to physician order). (_) Teach patient to request analgesics before pain becomes severe. (_) Explore non-pharmacological methods for reducing pain/ promoting comfort: • back rubs • slow rhythmic breathing • repositioning • diversional activities such as music, TV, etc. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Family Processes

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Illness of a family member:_____
(_) Loss/gain of family member due to:_____
_____
(_) Change in family roles:_____
(_) Conflict:_____
(_) Financial crisis:_____
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Family system cannot or does not adapt constructively to crisis or family system cannot or does not communicate openly and effectively between family members.
Minor: (*May be present*)	(_) Family system cannot or does not: • meet physical needs of all its members • meet emotional needs of all its members • meet spiritual needs of all its members • express or accept a wide range of feelings • seek or accept help appropriately

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The family member or patient will: (_) Frequently verbalize feelings to professional nurse and each other. (_) Maintain functional system of mutual support for each member. (_) Seek appropriate external resources when needed. (_) Other:		(_) Assess causative and contributing factors. (_) Meet with patient/family to identify: • strengths/weaknesses • resources available • needs • priorities • alternative arrangements • Other: (_) Encourage verbalization of guilt, anger, hostility, etc. and subsequent recognition of these feelings to: • nursing staff • family members (_)Direct family to hospital/ community agencies: • home health care • nurse discharge planners • social workers • other: (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Altered Growth and Development

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Acute illness (_) Prolonged pain (_) Chronic illness (_) Prolonged bedrest (_) Neglect/isolation	(_) Traction or casts (_) Separation from significant other (_) Parental knowledge deficit (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) _____ _____ _____
Minor: (*May be present*)	(_) _____ _____ _____

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The child/patient will: (_) Demonstrate an increase in personal, social, language, cognition, or motor activities appropriate to age group. Specify Behaviors:		(_) Assess present level of personal, social, cognitive and motor development. (_) Assess etiological factors for alteration in growth and development. (_) On admission, evaluate height and weight. (_) Daily weights at___ a.m./p.m.	

			using the same scale. (_) Provide opportunities for child to meet age related developmental tasks such as: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ (_) Teach parents appropriate developmental tasks and parental guidance information such as: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Health Maintenance

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Loss of independence (_) Changing support systems (_) Change in finances (_) Lack of knowledge (_) Poor learning skills (illiteracy) (_) Crisis situation (_) Inadequate health practice (_) Substance abuses:_____ _____	(_) Lack of accessibility to health care services (_) Health beliefs (_) Religious beliefs (_) Cultural/folk beliefs (_) Alterations in self image (_) Age related conditions (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Reports or demonstrates an unhealthy practice or life style. (_) Reckless driving of vehicle. (_) Substance abuse. (_) Overeating. (_) Reports or demonstrates frequent alterations in health. eg: _____

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Incorporate principles of health promotion into lifestyle: (_) Other:		(_) Assess for factors that contribute to the promotion and maintenance of health or that result in alterations in health. (_)Provide pertinent information concerning screening for: breast cancer, BP, other: _____ (_) Explore health promotion behaviors that patient is willing to incorporate into lifestyle. (_) Initiate health teaching and referrals as indicated: • review daily health practices • dental care • food intake • fluid intake • exercise • use of tobacco, alcohol, and drugs • knowledge of safety practices, fire prevention, water safety, automobile safety, bicycle safety, and poison control • other: (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Nutrition: Less Than Body Requirements

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Dysphagia caused by:_____ (_) Absorptive disorders (_) Anorexia (_) Allergy (_) Burns (_) Cancer (_) Chemotherapy (_) Chemical dependence (_) Crash or fad diet (_) Depression	(_) Inability to obtain food (_) Infection (_) Lack of knowledge of adequate nutrition (_) Nausea and vomiting (_) Radiation Therapy (_) Social isolation (_) Stress (_) Trauma (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Reported inadequate food intake less than recommended daily allowance with or without weight loss and/or actual or potential metabolic needs in excess of intake.
Minor: (*May be present*)	(_) Weight 10% to 20% or more below ideal for height and frame. (_) Tachycardia on minimal exercise and bradycardia at rest. (_) Muscle weakness and tenderness. (_) Mental irritability or confusion. (_) Decreased serumm albumin.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Experience adeuqate nutrition through oral intake. (_) Experience an increase in the amount or type of nutrients ingested. (_) Gain weight. (_) Other:		(_) Assess and document patient's dietary history, patters of ingestion, intolerance to foods. (_) Assess patient likes and dislikes. Inform dietary. (_) Teach techniques to maintain adequate nutritional intake and stimulate appetite: • administer/instruct pt. on good oral hygiene before and after feedings • maintain pleasant environment for patient (_) Determine proper denture fit and profice adhesive as necessary. (_) Increase social contact with meals by: _____ _____ (_) Plan care so that unpleasant/ painful tests/tx's don't take place before meals. (_) Medicate pt. for pain 2 hrs before meals per physician's orders. (_) Consult with dietitian re: • calorie count • change in food consistency • spacing meals • provision of high caloric supplements • provision of high protein supplementation	

			• food intolerances/ preferences • extra fluids on tray • dietetic teaching, food selelction • therapeutic diet restrictions: _____ (_)Consult with PT/PT re: • strengthening exercises • prosthetic devices • swallowing disorders (_) Environmental support to improve intake: • be sure pt. is alert and responsive before eating • sit upright 60-90 degrees for 15-20 min. before, during & after eating • decrease distractions • demonstrate patience by providing specific directions until finished • assure good mouth care (_) Weigh patient q_____ at _____ a.m./p.m. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Nurtition: More Than Body Requirements

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Altered satiety patterns
(_) Medications (steroids)
(_) Lack of knowledge
(_) Decreased activity
(_) Decreased metabolic needs
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Overweight (weigh 10% to 20% over ideal for height and frame. (_) Obese (weigh over 20% of ideal).
Minor: (*May be present*)	(_) Reported undesirable eating patterns. (_) Intake in excess of metabolic requirements. (_) Sedentary activity patterns.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Decrease total calories ingested. (_) Increase activity level. (_) Loose weight: (_____ pounds by discharge). (_) Other:		(_) Assess and document patient's dietary history, patterns of ingestion, activity patterns. (_) Discuss with patient potential causative factors for weight gain. (_) Assess motivation to correct overweight. (_) Consult with dietician regarding balanced plan for weight loss. Reinforce teaching. Discuss realistic weight loss of not more than 2 pounds per week. (_) Provide positive reinforcement for weight loss. (_) Record intake. (_) Weigh q ___ days at ____ am/ pm. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Impaired Adjustment

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Illness (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Verbalization of non-acceptance of health status change. (_) Inability to be involved in problem solving or goal setting.
Minor: (*May be present*)	(_) Lack of movement toward independence. (_) Extended period of shock, disbelief, or anger regarding health status change. (_) Lack of future oriented thinking.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Identify the temporary and long term demands of the situation. (_) Differentiate coping behavior that is effective vs. ineffective. (_) Other:		(_) Asses the patient's: • pre-morbid lifestyle • pre-morbid coping style • amount and type of resources available • extent of current disruption on life style • current level of stress • current coping methods and their effectiveness (_) Assist patient to identify the stressors.	

			(_) Explore feelings about situation with patient. (_) Identify factors that interfere with or delay effective adjustment: • unmanageable level of stress • ineffective problem solving • inadequate or unavailable resources • significant other(s) • inadequate coping mechanisms • explore effective coping mechanisms (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Impaired Gas Exchange

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Anesthesia (_) Allergic response (_) Altered level of consciousness (_) Anxiety (_) Aspiration (_) Decreased lung compliance (_) Edema of tonsils, adenoids, sinuses (_) Excessive or thick secretions (_) Fear (_) Immobility (_) Improper positioning	(_) Infection (_) Loss of lung elasticity (_) Medication (_) Neuromuscular impairment (_) Obstruction (_) Pain (_) Smoking (_) Surgery (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Dyspnea on exertion.
Minor: (*May be present*)	(_) Tendency to assume a three-point position (bending forward while supporting self by placing one hand on each knee). (_) Pursed lip breathing with prolonged expiratory phase. (_) Increased anteroposterior chest diameter, if chronic. (_) Lethargy and fatigue. (_) Increased pulmonary vascular resistance (increased pulmonary artery/right ventricular pressure). (_) Decreased oxygen content, decreased oxygen saturation, increased PCO2. (_) Cyanosis.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Demonstrate optimal gas exchange as permitted by clinical condition A.E.B.: • absence of cyanosis • ABG's are within acceptable limits. (_) Other:		(_) Assess color, respiratory rate and depth, effort, rythm q___. (_) Check for breath sounds q___. (_) Report ABG's that deviate from patient's baseline. (_) Position to facilitate optimum breathing patterns: • HOB elevated ___ deg. • turn q____ hrs. • other: (_) Cough and deep breath. (_) Suction q___ hrs. (_) Increase actibity as tolerated to facilitate diaphragm excursion. eg: _____ _____ (_) Encourage fluid intake to decrease viscosity of secretions (when indicated). (_) Explore with patient potential etiological factors contributing to impaired gas exchange and provide appropriate health teaching. (Discharge Plan) (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Impaired Home Maintenance Management

(_)Actual (_) Potential

Related To:

[Check those that apply]

Chronic debilitating disease: (_) Arthritis (_) Cancer (_) CHF (_) COPD (_) Diabetes mellitus (_) Multiple sclerosis (_) Muscular dystrophy	Injury to individual or family members: (_) Addition of family member (_) Loss of family member (_) Impaired mental status (_) Insufficient finances (_) Lack of knowledge (_) Substance abuse (_) Surgery (_) Unavailable support system (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Outward expressions by individual or family of difficulty in maintaining the home or in caring for self or family members.
Minor: (*May be present*)	(_) Poor hygiene practice. (_) Unwashed cooking/eating utensils. (_) Impaired caregiver. (_) Inadequate support system.

Date & Sign.	**Plan and Outcome** *[Check those that apply]*	**Target Date:**	**Nursing Interventions** *[Check those that apply]*	**Date Achieved:**

	The patient or caregiver will: (_) Identify factors that restrict self care and home management. (_) Demonstrate the ability to perform skills necessary for the care of the individual or home. (_) Express satisfaction with home. (_) Other:		(_) Assess for factors that might impair home management. (_) Explore with patient and/or significant other, factors that will facilitate home management and provide appropriate health teaching. (See Discharge Plan) (_) Procure necessary equipment or aids:_____ _____ _____ (_) Refer to/consult with appropriate agencies for: • insufficient funds: • cooking: • transportation: • housework: • home maintenance: • other: (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Impaired Physical Mobility

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Amputation (_) Cardiovascular (_) External devices (_) Impaired balance (_) Limited ROM (_) Musculoskeletal impairment	(_) Neuromuscular impairment (_) Pain (_) Surgical procedure (_) Trauma (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Inability to move purposefully within the environment, including bed mobility, transfers, and ambulation.
Minor: (*May be present*)	(_) Range of motion limitations. (_) Limited muscle strength or control. (_) Impaired coordination.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Maintain or increase strength and endurance of upper/lower limbs A.E.B.: (_) Will not develop complications of immobility. (_) Demonstrate use of adaptive		(_) Assess symmetry, strength, and degree of mobility. (_) Passive/active ROM exercises as ordered by physician q_____ to:_____ (body part). (_) Position in proper alignment and resposition q____ hrs. (_) Encourage isometric	

	device(s) to increase mobility. Device: (_) Other:		exercises when indicated. (_) Up in chair _____ minutes q____. (_) Check/teach proper use/ function of adaptive equipment. (_) Provide progressive mobilization. (_) Referral: • PT • OT • other: (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Impaired Skin Integrity

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Burns of_____
(_) Decreased sensation
(_) Immobility
(_) Malnutrition
(_) Pressure ulcer
(_) Puritus
(_) Stoma problems
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Disruption of epidermal and dermal tissue.
Minor: (*May be present*)	(_) Denuded skin. (_) Erythema. (_)Lesions. Other:

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_)Maintain or develop clean and intact skin. (_) Other:		(_) Inspect and chart skin integrity q_____hrs. (_) Do wound care/dressing change as ordered. Describe: _____ _____ _____ _____ _____ _____ (_) Provide measures to decrease pressure/irritation to skin: • fleece pad • egg crate mattress • keep skin clean and dry • other: (_) Turn and reposition q____hrs. (_) Up in chair for ___ minutes q____. (_) Gently massage bony prominences and pressure points with lotion q____. (_) Maintain adequate nutrition and hydration. (_) Change incontinent pad ASAP after voiding or defecation. (_) Expose skin to air if indicated. (_) Initiate health teaching and referrals as indicated. List: _____ _____ _____	

			(_) Keep nails short. (_) Mittens to decrease skin breakdown from scratching. (These are considered a restraint in some facilities. Get an order first.) (_) Change ostomy appliance prn when leaking. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Impaired Social Interaction

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Mental illness (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Reports inability to establish and/or maintain stable, supportive relationships.
Minor: (*May be present*)	(_) Lack of motivation. (_) Sever anxiety. (_) Dependent behavior. (_) Hopelessness. (_) Delusions/hallucinations. (_) Disorganized thinking. (_) Lack of self care skills. (_) Poor impulse control. (_) Distractibility/inability to concentrate. (_) Social isolation. (_) Superficial relationships. (_) Difficulty holding a job. (_) Lack of self esteem.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Identidy problematic behavior that deters socialization. (_) Describe and utilize strategies to promote effective socialization. (_) Other:		(_) Assess patients feelings relative to social isolation. (_) Help to identify precipitating factor(s)/stressors. (_) Help to identify alternative courses of action. (_) Assist in analyzing approaches which work best. (_) Provide supportive group therapy when indicated. (_) Encourage to validate perception with others. (_) Identify strengths and areas of improvement. (_) Role model certain accepted social behaviors:_____ _____ _____ (_) Hold accountable for own actions. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Impaired Verbal Communication

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Auditory impairment (_) Cerebral impairment (_) Fear/shyness (_) Lack of privacy (_) Lack of support system (_) Language barrier (_) Laryngeal edema/infection	(_) Neurologic impairment (_) Oral deformities (_) Pain (_) Respiratory impairment (_) Speech pathology (_) Surgery (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Innappropriate or absent speech or response.
Minor: (*May be present*)	(_) Stuttering. (_) Slurring. (_) Problem in finding the correct words when speaking. (_) Weak or absent voice. (_) Decreased auditory comprehension. (_) Deafness or inattention to noises or voices. (_) Confusion. (_) Inability to speak the dominant language of culture.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Demonstrate improved ability to express self A.E.B.: (_) Relate findings of decreased frustration and isolation with communication. (_) Other:		(_) Assess type of impairment. (_) Decrease environmental stimuli. (_) Be cognizant of possible cultural barriers. (_) Offer alternative forms of communication such as: • gestures or actions • pictures or drawings • magic slate • word board • flash cards that translate words/phrases (_) Encourage s/o to participate. (_) Validate patient's message by repeating aloud. (_) Use short repetitive directions. (_) Ask simple yes or no questions. (_) Speak on an adult level, speaking clearly and slower than normal. (_) Assess frustration level. Wait 30 seconds before providing patient with word. (_) Initiate health teaching. (_) Referrals: • Translator • Speech Pathologist. • Psychiatry • Other:	

			(_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Activity Intolerance

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Alterations in O2 transport (_) Chronic disease:_____ _____ (_) Depression (_) Diabetes Mellitus (_) Fatigue (_) Lack of motivation (_) Malnourishment	(_) Pain (_) Prolonged immobility (_) Stressors (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) _____ _____ _____

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Identify factors that reduce activity tolerance. (_) Progress to highest level of mobility possible. Describe: (_) Exhibit a decrease in anoxic		(_) Reduce or eliminate contributing factors by: • Assess patient's schedule. Allow rest periods between all activities. • Encourage person to note daily progress. • Evaluate patient's pain and the present treatment regimen. • Check pulse rates resting and after activity to avoid	

	signs of increased activity. (eg: BP, pulse, resp.) (_) Other:		danger of too great an increase. • Assess skin color (hands, nails, circumoral) before and after activity. • Relaxation training (work with pulmonary rehab.) • Cough/deep breathe. • Encourage fluid intake, roughage. • Teach inhaler use. • Sit when conversing with patient. • Progress the activity gradually. (_) Other:_____ _____ _____ _____	

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Anxiety

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Anesthesia
(_) Anticipated/actual pain
(_) Disease
(_) Invasive/noninvasive procedure:_____
_____
(_) Loss of significant other
(_) Threat to self-concept
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	[**Physiological**] (_) Elevated BP, P, R (_) Insomnia (_) Restlessnes (_) Dry mouth (_) Dilated pupils (_) Frequent urination (_) Diarrhea [**Emotional**] (_) Patient complains of apprehension, nervousness, tension [**Cognitive**] (_) Inability to concentrate (_) Orientation to past (_) Blocking of thoughts, hyperattentiveness

Date & Sign.	**Plan and Outcome** *[Check those that apply]*	**Target Date:**	**Nursing Interventions** *[Check those that apply]*	**Date Achieved:**

	The patient will: (_) Demonstrate a decrease in anxiety A.E.B.: • A reduction in presenting physiological, emotional, and/or cognitive manifestations of anxiety. • Verbalization of relief of anxiety. (_) Discuss/demonstrate effective coping mechanisms for dealing with anxiety. (_) Other:		(_) Assist patient to reduce present level of anxiety by: • Provide reassurance and comfort. • Stay with person. • Don't make demands or request any decisions. • Speak slowly and calmly. • Attend to physical symptoms. Describe symptoms: • Give clear, concise explanations regarding impending procedures. • Focus on present situation. • Identify and reinforce coping strategies patient has used in the past. • Discuss advantages and disadvantages of existing coping methods. • Discuss alternate strategies for handling anxiety. (Eg.: exercise, relaxation techniques and exercises, stress management classes, directed conversation (by nurse), assertiveness training) • Set limits on manipulation or irrational demands. • Help establish short term goals that can be attained. • Reinforce positive responses. • Initiate health teaching and referrals as indicated:	

			(_) Other:_____ _____ _____ _____	

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Ineffective Individual Coping

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Illenss:_____
_____
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Change in usual communication patterns (in acute). (_) Verbalization of inability to cope. (_) Inappropriate use of defense mechanisms. (_) Inability to meet role expectations.
Minor: (*May be present*)	(_) Anxiety (_) Reported life stress. (_) Inability to problem-solve. (_) Alteration in social participation. (_) Destructive behavior toward self or others. (_) High incidence of accidents. (_) Frequent illnesses. (_) Verbalization of inability to ask for help. (_) Verbal manipulation. (_) Inability to meet basic needs.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Verbalize feelings related to emotional state. (_) Identify individual strengths. (_) Identify coping mechanisms (new and old). (_) Utilize effective coping mechanisms as evidenced by: (_) Other:		(_) Encourage verbalization of feelings, perceptions, and fears. (_) Assist to set realistic goals. (_) Encourage independence by: _____ _____ _____ (_) Assist with identification of petential solutions to present problems. (_) Consult with: • Pastoral care • Social services • Psych services • Other: (_) Identify problems that cannot be controlled. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Discharge Care Plan

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	(_) The patient/family's discharge planning will begin on day of admission including preparation for education and/or equipment. (_) On the day of discharge, patient/family will receive verbal and written instructions concerning: • Medications • diet • Activity • Treatments • Follow up appointments • Signs and symptoms to observe for (when to contact the doctor) • Care of incisions, wounds, etc. (_) Other:		(_) Assess needs of patient/ family beginning on the day of admission and continue assessment during hospitalization. (_) Anticipated needs/services: • Respiratory equipment • Hospital bed • Wheel char • Walker • Home health nurse • Home PT/OT/ST (_) Involve the patient/family in the discharge process. (_)Discuss with physician the discharge plan and obtain orders if needed. (_) Contact appropraite personnel with orders. (_)Provide written and verbal instructions at the patient/family's level of understanding. (_) Verbally explain instructions to patient/family prior to discharge and provide patient/ family with a written copy. (_) Ascertain that patient has follow-up care arranged at discharge.	

			(_) Provide verbal and written information on what signs and symptoms to observe and when to contact the physician. (_) Assess if any community resources should be utilized (i.e.: Home Health Nurse), and contact appropriate personnel. (_) Document all discharge teaching on Discharge Instruction Sheet and Nursing notes. (_) Other:_____ _____ _____ _____	

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Disuse Syndrome

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Unconciousness (_) Neuromuscular Impairment (_) Musculoskeletal condition (_) Immobility (_) Traction/casts/splints (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Presence of risk factors. (See above "Related To").

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Maintain or regain free range of motion of extremities within limits of disease. (_) Maintian or regain function of: _____ _____ within limits of disease. (_) Other:		(_) Assess range of motion of affected extremities and the ability of patient to perform ADL's. (_) Consult with PT/OT regarding necessary exercises/assistive devices. (_) Range of motion to_____ extremities _____ times a day. (_) Splints to _____. Apply	

			during _____. Remove for _____. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Diversional Activity Deficit

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Monotonous environment
(_) Long-term hospitalization
(_) Lack of motivation with signs of depression
(_) Skeletal-muscular impairments
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Observed statement of boredom/depression fro inactivity.
Minor: (*May be present*)	(_) Constant expression of unpleasant thoughts or feelings. (_) Yawning or inattentiveness. (_) Flat facial expression. (_) Restlessnes/fidgeting. (_) Body language (shifting of body away from speaker). (_) Immobile (on bed rest or confined). (_) Weight loss or gain. (_) Hostility.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Recognize feelings of boredom and discuss methods of finding diversional activities. (_) Engage in group or individual diversional activity. (_) State satisfaction with use of one's time. (_) Other:		(_) Assess causative factors: • Monotony • Inability to make decisions • Diminished socialization. • Lack of motivation (_) Obtain an activity assessment (find our hobbies, likes and dislikes): _____ _____ _____ (_) Assist in selection of an activity that is seen as having value and importance: _____ _____ (_) Include above activity in daily routine of care. (_) Involve patient in own care by: _____ _____ _____ (_) Increase environmental stimulation of sight and sound by: _____ _____ _____ (_) Consult wiith other departments: • Pastoral care • Occupational therapy • Volunteers (_) Other:_____ _____ _____	

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Patient/Significant other signature

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Fear

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Invasive procedures
(_) Hospitalization
(_) Loss of s/o
(_) Pain
(_) Anesthesia
(_) Surgery
(_) Disability/chronic/acute/terminal illness: _____
(_) Lack of knowledge:_____ _____
(_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Feelings of dread, fright, apprehension and/or behaviors of avoidance. (_) Narrowing of focus on danger. (_) Deficits in attention, performance, and control.
Minor: (*May be present*)	(_) Verbal reports of panic. (_) Obsessions - acts of aggression, escape, hypervigilance, dysfunctional immobility, compulsive mannerisms, increased questioning/verbalization. (_) Visceral-somatic activity: Musculoskeletal (muscle tightness, fatigue), cardiovascular (palpitations, rapid pulse, increased blood pressure), respiratory (shortness of breath, increased rate), gastrointestinal (anorexia, nausea/vomitting, diarrhea), Genitourinary (urinary frequency), skin (flush/pallor, sweating, paresthesia) CNS/perceptual (syncope, insomnia, lack of concentration, irritability, absentmindedness, nightmares, dilated pupils).

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Discuss his/her fears. (_) Differentiate real from imagined situations. (_) Identify his/her own coping responses. (_) Recognize effective and ineffective coping patterns. (_) Experience increase in psychological and physiological comfort as evidenced by: (_) Other:		(_) Assess possible contributing factors. (_) Reduce or eliminate contributing factors by: • Orient to environment using simple explanations. • Speak slowly and calmly. • Avoid surprises and painful stimulus. • Use familiar routine. (_) Allow personal space. (_) Remain with person until fear subsides. (_) Utilize family members and s/o to stay with him/her. (_) Encourage expression of feelings. (_) Refocus interaction on areas of capability rather than dysfunction. (_) Encourage patient to face the fear. (_) Provide information to reduce distortions. (_) Age related fears: • Provide child opportunities to express fears. • Acknowledge illness, death, pain as real. • Encourage open, honest sharing. • Discuss with parents the normalcy of fear in	

			children. (_) Provide or demonstrate methods that increase comfort or relaxation: • Progressive relaxation techniques. • Reading, music, breathing exercises. • Thought stopping, guided fantasy. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Fluid Volume Deficit

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Excessive urinary output.
(_) Inadequate fluid intake.
(_) Abnormal drainage.
(_) Excessive emesis.
(_) Difficulty in swallowing.
(_) Medication:_____
(_) Diarrhea (_) Shock (_) Hemorrhage (_) Fever (_) Burns
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Output greater than intake. (_) Dry skin/mucous membranes.
Minor: (*May be present*)	(_) Increased serum sodium. (_) Increased pulse from baseline. (_) Decreased or excessive urine output. (_) Concentrated urine. (_) Urinary frequency. (_) Decreased fluid intake. (_) Poor skin tugor. (_) Thirst/nausea/anorexia.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Demonstrate adequate fluid balance A.E.B.: • Moist mucous membranes. • Balanced intake and output. • Normal lab values. • Improved skin turgor. (_) Other:		(_) Asses: • Moistness of mucous membrane and skin turgor and chart findings. • Intake and output q___ hours. • Orthostatic hypotension QD. • Daily weights each _____ am/pm using same scale. • Labs: HCT, BUN, Specific gravity, Sodium, Other: _____ (_) Encourage fluid intake of _____ cc/day; ____. (_) Assist patient with drinking if necessary. (_) Explore patient's understanding of etiological factors and provide necessary teaching. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Fluid Volume Excess

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Decreased cardiac output (_) Low protein intake (_) Liver disease (_) Inflammatory process (_) Steroid therapy	(_) Medications:_____ (_) Excess fluid intake (_) Sodium intake more than adequate (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Edema (_) Taught, shiny skin

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Have decreased edema in extremities. (_) Other:		(_) Reduce or eliminate causative contributing factors: _____ _____ (_) Assess location and severity of edema q ____ hours. (_) Measure intake and output. (_) Measure edematous extremity (ies) or abdominal girth q __. (_) Daily weights each ____ am/ pm using same scale.	

			(_) Elevate _____ extremity (ies) ____ degrees. (_) Passive/active range of motion exercises of _____ q ___ hours. (_) Avoid constrictive clothing. (_) Explore with patient potential etiological factors for edema and provide health teaching. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Greiving

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Loss of function of body part:_____
(_) Loss of s/o:_____
(_) Loss of independence/change in lifestyle.
(_) Diagnosis of a terminal illness.
(_) Loss of physical abilities:_____
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Unsuccessful adaptation to loss (_) Expressed distress of actual or potential loss (_) Prolonged denial (_) Depression (_) Delayed emotional reaction
Minor: (*May be present*)	(_) Social isolation or withdrawl (_) Failure to develop new relationships/interests (_) Failure to restructure life after a loss (_) Denial (_) Guilt (_) Anger (_) Sorrow (_) Change in eating habits (_) Change in sleep patterns (_) Decreased libido (_) Change in communication patterns

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Express his/her grief. (_) Describe the meaning of the death or loss to him/her. (_) Share his/her grief with s/o. (_) Participate in ADL's as tolerated. (_) Other:		(_) Assess for causative and contributing factors that may delay the grief process: _____ _____ _____ (_) Reduce or eliminate causative or contributing factors if possible. (_) Encourage to recognize grief situation. (_) Give opportunity for questions. (_) Encourage expressions of anger/concerns. (_) Describe the stages of anticipatory grieving. (Include s. o). (_) Have patient identify support systems. (_) Assist with unfinished business. (_) Encourage to share prognosis with s/o. (_) Encourage s/o to participate in care. (_) Encourage problem solving with help of others. (_) Encourage planned, "one day at a time" living. (_) Allow patient opportunity to identify own self care needs: _____	

			_____ _____ (_) Help to set realistic goals - give realistic hope: _____ _____ _____ (_) Encourage patient and s/o to accept individual responses to impending loss. (_) Refer/order consult: • Pastoral care • Social services • Home health care • Psychiatry (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Hyperthermia

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) CNS Pathology (_) Dehydration (_) Exposure to heat/sun (_) Impaired physical environment (_) Infection	(_) Inflammation (_) Peripheral neuropathy related to injury (_) Vigorous activity Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Temperature over 37.8 C (100 F) orally, or 38.8 C (101 F) rectally.
Minor: (*May be present*)	(_) Flushed skin (_) Warm to touch (_) Increased respiratory rate (_) Tachycardia (_) Shivering/goose pimples (_) Dehydration (_) Malaise/weakness (_) Loss of appetite

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Maintian normal body temperature. (_) Other:		(_) Assess temperature q ___ hours. (_) Assess possible etiology of increased temperature. (_) Encourage fluids when indicated. (_) Administer antipyretics per physician's order. (_) Remove excess clothing or	

			blankets. (_) Provide air condition/fan if appropriate. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Hypothermia

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) CNS pathology
(_) Decreased ability to shiver
(_) Exposure to the cold
(_) Impaired physical environment
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Reduction in body temperature below 35 C (95 F) orally, or 35.5 C (96 F) rectally. (_) Cool skin (_) Moderate pallor (_) Shivering (mild)
Minor: (*May be present*)	(_) Mental confusion/drowsiness/restlessness (_) Decreased pulse and respirations (_) Cachexia/malnutrition

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Maintain normal body temperature. Other:		(_) Assess temperature q ___ hours. (_) Asses for possible etiology of hypothermia. (_) Keep room temperature between 70-74 F. (_) Aply extra blankets. (_) Use warming blanket per physician's order to maintain	

			normal body temperature. (_) Provide intravenous solutions through a blood warmer per physician's order. (_) Rewarm patient gradually to prevent complications of rapid rewarming. (_) Teach patient to avoid extremes of cold weather and to dress adequately when exposed to cold. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Altered Oral Mucous Membranes: Stomatitis

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Immunosupression from chemotherapy
(_) Nutritional depletion
(_) Radiation to head and neck
(_) Improper fitting dentures
(_) Excessive dry mouth
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Disruption of mucous membrane tissue. (_) Lesion
Minor: (*May be present*)	(_) Coated tongue (_) Dry mucous membranes (_) Edema (_)Erythema (_) Leukoplakia

Date & Sign.	**Plan and Outcome** *[Check those that apply]*	**Target Date:**	**Nursing Interventions** *[Check those that apply]*	**Date Achieved:**

	The patient will: (_) Be free of oral mucosa irritation. (_) Exhibit signs of healing with decrease inflammation. (_) Other:		(_) Obtain history of radiation or chemotherapy regimen. (_) Check for oral burning, pain, or change in tolerance to temperature. (_) Do oral exam noting evidence of lesions within the mouth and tongue q____. (_) Oral hygiene q____ hours using: _____ (_) Teach patient to: • avoid commercial mouth washes, citrus fruit juices, spicy foods, extremes in food temperature, crusty or rough foods • use straw to facilitate fluids bypassing inflammed lesions (if indicated) • use soft tooth brush or toothettes for oral care • check for proper fit of dentures (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

RN signature

Alteration in Parenting

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Abusive	(_) Emotionally disturbed
(_) Accident victim	(_) Lack of extended family
(_) Acutely disabled	(_) Lack of knowledge
(_) Addicted to drugs	(_) Relationship problems
(_) Adolescent	(_) Separation from nuclear family
(_) Alcoholic	(_) Single parent
(_) Breastfeeding difficulties	(_) Terminally ill
(_) Change in family unit	(_) Unrealistic expectations of self, infant, partner
(_) Economic problems	(_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Innappropriate parenting behaviors. (_) Lack of parental attachment behavior.
Minor: (*May be present*)	(_) Frequent verbalization of dissatisfaction or disappointment with infant/child. (_) Verbalization of frustration of role. (_) Verbalization of perceived or actual inadequacy. (_) Diminished or inappropriate visual, tactile, or auditory stimulation. (_) Evidence of abuse or neglect of child. (_) Growth and development lag in infant/child.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Begin to verbalize positive feelings re: child, self. (_) Demonstrate increased attachment behaviors such as holding infant close, talking to infant, eye contact. (_) Initiate active role in child's care. (_) Identify activities that defer and promote successful breast feeding. (_) Identify outside resources for support/guidance: _____ (_) Demonstrate ability to care for infant. (_) Identify support system. (_) Other:		(_) Assess causative or contributing factors. (_) Eliminate/reduce contributing factors. (_) Promote ongoing attachment process by:_____ _____ _____ (_) Assist to identify and contact appropriate outside resources. (_) Will assist patient to identify support system and assess strengths and weaknesses. (_) Provide support to parents/ support system by:____ _____ _____ (_) Provide interventions that promote parents and s/o self esteem. (_) Counsel the parent(s) on assessed needs. (_) Consult with:_____ _____ _____ (_) Encourage mother/father to feed, diaper, dress, bathe child. (_) Promote successful breastfeeding by: • proper positioning • eye to eye contact • feeding on demand • encourage rooming in	

			• proper latching on of infant to breast • other (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Sensory Perceptual

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Amputation	(_) Paraplegia
(_) Bedrest	(_) Physical isolation
(_) Cast	(_) Social isolation
(_) Hearing	(_) Stress
(_) Immobility	(_) Traction
(_) Impaired oxygen transport	(_) Visual
(_) Medications	(_) Other:_____
(_) Metabolic alterations	_____
(_) Neurological alterations	_____
(_) Pain	

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Inaccurate interpretation of environmental stimuli. (_) Negative change in amount or pattern of incoming stimuli.
Minor: (*May be present*)	(_) Disoriented about person, place, or time. (_) Altered problem solving ability. (_) Altered behavior or communication pattern. (_) Sleep pattern disturbances. (_) Restlessness. (_) Reports auditory or visual hallucinations. (_) Fear. (_) Anxiety. (_) Apathy.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Demonstrate optimal contact with reality. (_) Demonstrate an increase in self care activities. (_) Experience decreased symptoms of sensory overload. (_) Other:		(_) Assess ability of patient to accurately interpret sensory stimuli. (_) Monitor electrolytes, adequacy of BP. (_) Organize nursing care to provide uninterrupted sleep at night. (_) Reduce unessential stimuli, if possible. Orient to person, place, and time with every nurse/patient contact. (_) Encourage interaction with familiar persons. (_) Explain all nursing care. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Altered Sexuality Patterns

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Cardiac disease (_) Chronich respiratory disease (_) Medication (_) Metabolic disease (_) Neurological disease	(_) Penile prosthesis (_) Prostatectomy (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Identification of sexual difficulties, limitations, or changes.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Experience sexual pleasure as defined by self and partner. (_) Learn alternative ways of sexual expresiion. (_) Other:		(_) Assess patient's current satisfaction with sexual functioning. (_) Discuss with patient potential etiological factors for a change in sexual functioning. (_) Teach patient necessary information regarding implantable devices. eg. penile prosthesis. (_) Referral to: _____ _____ _____	

			(_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Thought Processes

(Geriatrics)

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Factors associated with aging. (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Inaccurate interpretation of stimuli, internal and/or external.
Minor: (*May be present*)	(_) Cognitive defects, including abstraction, memory, suspiciousness, delusions, hallucinations, distractibility, lack of consensual validation, language, confusion/ disorientation.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Demonstrate optimum contact with reality. (_) Demonstrate an increase in self-care activities. (_) Other:		(_) Assess for etiological and contributing factors: • physiological • situational (_) Assess history of confusion (onset/duration). (_) Determine the amount and type of stimuli needed by the patient in the context of his/her usual life style.	

			(_) Promote communication and sensory input. (_) Promote a well role: • encourage ADL's per patient as much as possible • meals out of bed yes/ no_____ • other: (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Alteration in Patterns of Urinary Elimination: Incontinence

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Congenital urinary tract anomalies: _____ (_) Disorders of urinary tract:_____ _____ (_) Drug therapy (_) Environmental barriers to bathroom (_) Estrogen deficiency (_) Inability to communicate needs	(_) Lack of privacy (_) Loss of perineal tissue tone (_) Neurogenic disorder or injury (_) Prostatic enlargement (_) Stress/fear (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Urgency followed by incontinence. (_) Other:

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Be continent at all times. (_) Be continent during waking hours. (_) Other:		(_) Montiro I & O, including patterns of urinary incontinence. (_) Instruct to start and stop stream during urination. (_) Ask physician for pelvic floor exercises. Order and teach as follows: _____x_____ (# of times). (_) Limit fluids 2-3 hours prior to bedtime. (_) No fluids after:_____ (_) Awaken patient at night to void at:_____ or q___hours. (_) Provide urinal/bedpan/ bedside commode in easy access. (_) Place call light within reach at all times. (_) Provide comfort measures (sitz baths: warm perineal soaks as needed). (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Alteration in Patterns of Urinary Elimination: Retention

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Anxiety
(_) Fecal impaction
(_) Flaccid bladder
(_) Medications
(_) Packing
(_) Stones
(_) Weak or absent sensory and/or motor impulses
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Bladder distention (not related to acute, reversible etiology). (_) Distention with small frequent voids or dribbling (overflow incontinence). (_) 100 ml or more residual of urine.
Minor: (*May be present*)	(_) The individual states that it feels as though the bladder is not empty after voiding.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Void in the amount of: _____ (_) Have urine resicual less than 30cc. (_) Verbalize knowledge of signs and symptoms of infection. (_) Other:		(_) Palpate bladder for distention q___ hours or after each void. (_) Monitor I & O. (_) Attempt to stimulate relaxation of urethral sphincter by: • running water • providing warm water for patient to place hand/ fingers in • other: (_) Provide privacy. (_) Intermittent straight cath q___ hours per physician order. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Knowledge Deficit

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) New diagnosis:_____
(_) Language differences:_____
(_) Hospitalization
(_) Diagnostic test:_____
(_) Surgical procedure:_____
(_) Medications:_____
(_) Pregnancy
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Verbalizes a deficiency in knowledge or skill. (_) Requests information. (_) Expresses and inaccurate perception of health status. (_) Does not correctly perform a desired or prescribed health behavior.
Minor: (*May be present*)	(_) Lack of integration of treatment plans into daily activities. (_) Exhibits or expresses psychological alteration, (anxiety, depression) resulting from misinformation or lack of information.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Describe disease process, causes, factors contributing to symptoms. (_) Describe procedure(s) for disease or symptom control. (_) Identify needed alterations in lifestyle. (_) Other:		(_) Assess patient's readiness to learn by assessing emotional respose to illness: • Acceptance • Anger • Anxiety • Denial • Depression • Other: (_) Allow person to work through and express intense emotions prior to teaching. (_) Examine patient's health beliefs: _____ _____ (_) Assess patient's desire to learn. (_) Assess preferred learning mode: • Auditory • Group • One to one • Visual • Other: (_) Assess literacy level. (_) Provide health teaching and referrals: _____ _____ _____ _____ (_) Plan and share necessity of learning outcomes with patient - s/o.	

			(_) Evaluate patient - s/o behaviors as evidence that learning outcomes have been achieved: _____ _____ _____ (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Ineffective Airway Clearance

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Atrificial airway
(_) Excessive or thick secretions
(_) Inability to cough effectively
(_) Infection
(_) Obstruction/restriction
(_) Pain
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Ineffective cough. (_) Inability to remove airway secretions.
Minor: (*May be present*)	(_) Abnormal breath sounds. (_) Abnormal respiratory rate, rythm, depth.

Date & Sign.	**Plan and Outcome** *[Check those that apply]*	**Target Date:**	**Nursing Interventions** *[Check those that apply]*	**Date Achieved:**

	The patient will: (_) Maintain patent airway A.E.B.: • Clear breath sounds or breath sounds consistent with own baseline. • Respirations easy and un-labored. • Normal resp. rate. (_) Other:		(_) Assess respiratory rate, depth, rythm, effort, and breath sounds q ___ hours. (_) Position: HOB elevated ___ degrees. (_) Promote optimum level of activity for best possible lung expansion: • Ambulate q ___ for ___ min. • Chair q ___ for ___ min. • Turn/reposition q ___. (_) Suction q ___ hours (and prn) per: • Nasal • Oral • Tracheal (_) Encourage fluids when indicated. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Ineffective Breathing Patterns

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Allergic response (_) Anesthesia (_) Aspiration (_) COPD (_) Decreased lung compliance (_) Fatigue (_) History of smoking	(_) Immobility (_) Medications (narcotics, sedatives, analgesics) (_) Neuromuscular impairment (eg. MS, Guillain-Barre) (_) Surgery or trauma (_) Pain (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Changes is respiratory rate or pattern from baseline. (_) Changes in pulse (rate, rythm).
Minor: (*May be present*)	(_) Orthopnea (_) Tachypnea (_) Hyperpnea (_) Splinted, guarded respirations.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Demonstrate an effective respiratory rate, depth, and pattern A.E.B.: • Color pink/ absence of cyanosis. • Absence of diminished breath sounds. (_) Other:		(_) Assess color, respiratory rate, depth, effort, rythm and breath sounds q ___ hours. (_) Position to facilitate optimum breathing patterns: • HOB elevated ___ degrees. • Turn q ___ hours. (_) Cough and deep breath q ___	

			hours. (_) Increase activity as tolerated to promote maximum diaphragmatic excursion: _____ _____ _____ _____ (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Noncompliance

(_) Exercise (_) Follow-up Care (_) Medication (_) Other

Related To:

[Check those that apply]

(_) Chronic illness (_) Fatigue (_) Depression (_) Non supportive family (_) Inadequate/incomplete instructions (_) Denial of Dx	(_) Side effects of therapy/med (_) Impaired ability to perform tasks (_) Expensive therapy (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Verbalization of non-compliance or non-participation or confusion about thrapy and/or (_) Direct observation of behavior indicating non-compliance
Minor: (*May be present*)	(_) Missed appointments (_) Partially used or unused medications (_) Progression of disease process. (_) Persistance of symptoms

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Demonstrate compliance with: (_) Other:		(_) Assess patient's: • Understanding of disease process • Barriers to compliance • Life-style • Support system • Perception of non-compliance • Other: (_) Allow patient and s/o to verbalize feelings about situation/	

			(_) Adapt regime to patient's level of comprehension. (_) Involve patient - s/o in planning compliance. (_) Emphasize positive aspects of compliance. (_) Instruct patient - s/o about meds: • Side effects • Dosage • Other: (_) Set goals with patient. (_) Consult with: • PT • OT • Home Health • Social Services (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Potential for Infection

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Alteration in skin integrity:_____
_____
(_) Bone marrow depression.
(_) Indwelling catheter:_____
(_) Nutritional deficiencies:_____
_____
(_) Surgical/invasive procedures:_____
_____
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Altered production of leukocytes. (_) Altered immune response.
Minor: (*May be present*)	(_) Altered circulation. (_) Presence of favorable conditions for infection. (_) History of infection.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Remain infection free A.E.B.: (_) Demonstrate complete recovery from infection A.E.B.: (_) Other:		(_) Assess temperature q ___ hrs. (_) Inspect and record signs of erythema, induration, foul smelling drainage, from or around wound, skin, invasive line, mouth/throat, or other site q ___ hrs. (_) Asses for cloudiness of urine q ___ hrs. (_) Report abnormal changes in WBC count and/or pathogenic growth on cultures. (_) Utilize good handwashing techinque. (_) Visitors and health care workers with active infection are to avoid contact with patient. (_) Avoid invasive prodecures; i. e. rectal temperatures, bladder catheters, etc. (_) Encourage high protein/high carbohydrate foods/fluids when indicated. (_) Explore with patient potential etiological factors which potentiate infection and include appropriate health teaching. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Powerlessness

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Inability to communicate:_____
(_) Inability to perform ADL:_____
(_) Inability to perform role responsibilities:_____
_____
(_) Progressive debilitating disease:_____
(_) Hospital or institutional limitations:_____
_____
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Overt or covert expressions of dissatisfaction over inability to control situation. (exg: illness, prognosis, care, recovery rate)
Minor: (*May be present*)	(_) Refuses or is reluctant to participate in decision-making (_) Apathy (_) Resignation (_) Aggressive/violent/acting out behavior (_) Anxiety (_) Uneasiness (_) Depression

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Identify factors that can be controlled: (_) Makes decisions regarding treatment and future when possible. (_) Other:		(_) Assess causative or contributing factors. (_) Assess patient's usual response to problems: • Internal - how individual makes own changes • External - expects others to control problems or leaves to fate, or luck (_) Increase communication • Explain all procedures and.. • Treatments • Medications • Results of labs/tests • Condition • All changes • Rules • Options • Other: (_) Allow time to answer questions (15 min. ea shift) (_) Realistically point out positive changes in person's condition. (_) Allow patient to make as many decisions as possible. (_) Provide opportunities for patient and family to participate in care. (_) Encourage participation from patient who depends on others to make own decisions.	

			(_) Encourage patient to verbalize feelings and concerns. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Rape Trauma Syndrome

(_)Actual (_) Potential

Related To:

[Check those that apply]

Somatic Response: (_) Gastrointestinal irritability (N/V, anorexia) (_) Genitourinary discomfort (pain, puritus) (_) Skeletal muscle tension (spasm, pain) (_) Other:_____ _____ Sexual responses: (_) Mistrust of men (if victim is woman) (_) Change in sexual behavior Other:_____ _____	Psychological responses: (_) Denial (_) Emotional shock (_) Anger (_) Fear (_) Guilt (_) Panic on seeing assailant or scene of attack (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Reports or evidence of sexual asault
Minor: (*May be present*)	If the victim is a child, parent(s) may experience similar responses: Acute Phase: • Somatic responses: Gastro-intestnal irritability (N/V, anorexia) Genitourinary discomfort (pain, pruritus) Skeletal muscle tension (spasm, pain) • Psychological responses: Denial, emotional shock, anger, fear of being alone or that the rapist will return [a child victim will fear punishment, repercussions, abandonment, rejection] guilt, panic on seeing assailant or scene of attack • Sexual responses: Mistrust of men (if victim is a woman), change in sexual behavior. Long term phase: • Any response of the acute phase may continue if resolution does not occur. • Psychological responses: Phobias, nightmares, or sleep disturbances

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Experience decreased symptoms of: (_) Discuss assult. (_) Express feelings concerning the assault and the treatment. (_) Identify members of support system and utilize them appropriately. (_) Return to pre-crisis level of functioning. (_) Other:		(_) Assess for psychological responses: • Phobias • Denial • Anger • Depression • Guilt • Other: (_) Inspect urine and external genitalia for bleeding. (_) Observe patient's behavior carefully and record objective data. (_) Promote trusting relationship. (_) Provide crisis counseling within one hour of rape trauma event. (_) Help patient meet personal needs of: _____ (_) Allow patient to express feelings. (_) Discuss with patient previous coping mechanisms. (_) Explore with patient her/his strengths and resources. (_) Offer feedback to patient on	

			feelings verbalized. (_) Explore sexual concerns with patient. (_) Initiate health teaching and referrals as necessary. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Self Care Deficit: Bathing

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Neuromuscular impairment (_) Visual disorders (_) Trauma or surgical procedure (_) External devices (_) Aging process	(_) Musculoskeletal disorders (_) Immobility (_) Nonfuntioning or missing limbs (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Unable or unwilling to wash body or body parts. (_) Unable to obtain water. (_) Unable to regulate temperature or water flow.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Perform bathing activity at expected optimal level. (_) Demonstrate use of adaptive devices for bathing. (_) Other:		(_) Assess for causative factors. (_) Provide opportunities to relearn or adapt to activity. (_) Teach patient to use affected extremity to accomplish tasks. (_) Consistent bathing routing at ___ am/pm every day. (_) Provide as much privacy as possible by pulling curtains and closing doors.	

			(_) Provide equipment within easy reach. (_) Encourage independence. (_) Reinforce success for task accomplished. (_) OT consult for: • Adaptive devices • Safety measures for home • Other: (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Self Care Deficit: Dressing and Grooming

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Neuromuscular impaitment:_____
(_) Impaired visual actuity
(_) Immobility
(_) Weakness
(_) Decreased level of consciousness
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Impaired ability to put on or take off clothing. (_) Unable to obtain or replace article of clothing. (_) Unable to fasten clothing. (_) Unable to groom self satisfactorily

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Demonstrate increased ability to dress/groom self. (_) Demonstrate ability to cope with the necessity of having someone else assist him/her in performing the task. (_) Demonstrate ability to learn how to use adaptive devices to		(_) Allow sufficient time for dressing and undressing, since the task may be tiring, painful, and difficult. (_) Promote independence in dressing through continual and unaided practice. (_) Choose clothing that is loose fitting, with wide sleeves and pant legs, and front fasteners.	

	facilitate optimal independence in the task of dressing/grooming. (_) Other:		(_) Lay clothes out in the order in which they will be needed to dress. (_) Avoid placing clothing to blind side if patient has field cut, until patient is visually accommodated to surroundings; encourage patient to turn head to scan entire visual field. (_) Consult/refer to PT/OT for teaching application of prosthetics. (_) Provide dressing aids as necessary (dressing stick, swedish reacher, zipper pull, button-hook, long handled shoehorn, shoe fasteners adapted with elastic laces, velcro closures, flip back tongues). (_) Plan for person to learn and demonstrate one part of an activity before progressing further. (_) Make consistent dressing/ grooming routine to provide a structured program to decrease confusion. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

RN signature

Sleep Pattern Disturbance

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Impaired oxygen transport (_) Impaired elimination (_) Impaired metabolism (_) Immobility (_) Medication (_) Hospitalization	(_) Lack of exercise (_) Anxiety response (_) Life-style disruptions (_) Other:_____ _____ _____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Difficulty falling or remaining asleep
Minor: (*May be present*)	(_) Fatigue on awakening or during the day (_) Dozing during the day (_) Agitation (_) Mood alterations

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Demonstrate an optimal balance of rest and activity A.E. B. ___ hours of uninterrupted sleep at night. (_) Remain awake during the day. (_) Other:		(_) Explore with patient potential contributing factors. (_) Maintain bedtime routine per patient preference. • Likes to go to bed @ ___ pm. • Prefers quiet • Darkness • Night light • Music (_) Takes sleeping pill as ordered	

			by a physician @ ____ pm. (_) Provide comfort measures to induce sleep: • Back rub • Herbal tea-warm milk • Pillows for support • Bedtime snack when appropriate. • Pain medication if needed. • Other: (_) Limit nighttime fluids to: _____ (_) Void before retiring. (_) Coordinate treatment/meds to limit interruptions during sleep period. (_) Limit the amount and length of daytime sleeping: _____ (_) Increase daytime activity: _____ _____ _____ _____ (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Social Isolation

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Death of s/o
(_) Divorce
(_) Substance abuse
(_) Illness:_____
_____
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Expressed feelings of unexplained dread or abandonment (_) Desire for more contact with people
Minor: (*May be present*)	(_) Time passing slowly (_) Inability to concentrate and make decisions (_) Feelings of uselessness (_) Doubts about ability to survive

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Identify the reasons for his/ her feelings of isolation. (_) Identify ways of increasing meaningful relationships. (_) Identify appropriate diversional activities. (_) Other:		(_) Encourage patient to verbalize feelings. (_) Assist to identify causative and contributing factors. (_) Assist to reduce or eliminate causative and contributing factors: _____ _____ _____	

			(_) Assist to identify diversional activities. (See Diversional Activity Deficit) (_) Initiate referrals as needed or increase social relationships: _____ _____ _____ (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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Spiritual Distress

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Pain
(_) Trauma
(_) Loss of body part/function
(_) Terminal illness
(_) Death of s/o
(_) Unable to practice religious rituals
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) Experiences a disturbance in belief system.
Minor: (*May be present*)	(_) Questions credibility of belief system. (_) Demonstrates discouragement or despair. (_) Is unable to practice usual religious rituals. (_) Has ambivalent feelings (doubts) about beliefs. (_) Expresses that he/she has no reason for living. (_) Feels a sense of spiritual emptiness. (_) Shows emotional detachment from self and others. (_) Expresses concern, anger, resentment, fear - over the meaning of life, suffering, death. (_) Requests spiritual assistance for a disturbance in belief system.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:

	The patient will: (_) Continue spiritual practices not detrimental to health. (_) Express decreasing feelings of guilt and anxiety. (_) Express satisfaction with spiritual condition. (_) Other:		(_) Assess current level of spiritual state: Comfort, distress, desire for minister, priest, rabbi to visit, desire to practice religious rituals. (_) Implement patient requests regarding spiritual needs. (_) Contact spiritual/religious advisor of patients choice. (_) Discuss impact of stress on challenging one's spiritual beliefs. (_) As patient desires, allow opportunity to discuss belief system, the meaning of illness/ suffering within this system. (_) Other:_____ _____ _____ _____	

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Patient/Significant other signature

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RN signature

Violence

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) Acute agitation
(_) Poor impluse coordination
(_) Mania
(_) Feelings of helplessness
(_) Other:_____
_____
_____

As evidenced by:

[Check those that apply]

Major: (*Must be present*)	(_) History of harm to others (_) Destruction of property (_) Overt aggressive acts
Minor: (*May be present*)	(_) Acute agitation (_) Suspiciousness (_) Persecutory delusions (_) Inflexible (_) Verbal threats of physical assault (_) Low frustration tolerance (_) Poor impulse control (_) Feelings of helplessness (_) Excessively controlled

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Experience control of behavior with assistance from others. (_) Describe causation and possible preventative measures. (_) Other:		(_) Assess patient's potential for violence and past history. (_) Maintain patient's personal space, (i.e. allow 5 times greater space than that for individual in control). (_) Seclusion: Check q _____ (_) Restraints:_____ Check q ___	

			(_) Set limits: _____ (_) Decrease noise level. (_) Provide environment that provides safety and reduces agitation: _____ _____ (_) Acknowledge feelings. (_) Explore the precipitating event. (_) Other:_____ _____ _____ _____	

_____
Patient/Significant other signature

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RN signature

_____

(_)Actual (_) Potential

Related To:

_____
_____
_____
_____
_____

As evidenced by:

Major: (*Must be present*)	_____ _____ _____ _____ _____
Minor: (*May be present*)	_____ _____ _____ _____ _____

Date & Sign.	Plan and Outcome	Target Date:	Nursing Interventions	Date Achieved:

	The patient will:			

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Patient/Significant other signature

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RN signature

- Online Nursing School
- Nursing Continuing Education
- Student Loans
- Student Loan Consolidation
- Travel Nurse Jobs
- Nursing
- Nursing Programs
- Nursing Careers
- Healthcare Degree
- Online Nursing Degree
- School Loans

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