

## **Module 6**

### **NURSING CARE PLANNING**

#### **INTRODUCTION**

This module on nursing care planning is a follow-up to Module 5, Nursing Process.

#### **OBJECTIVES**

Upon completion of this module, you should be able to:

- Relate the ANA Standards of Nursing Practice to nursing care planning.
- State the importance of the written nursing care plan.
- Describe the technique for utilizing standardized care plans.
- Explain the relevance of computerization to nursing care planning.

#### **COMMENTS**

When you finished nursing school, you may have thought that care plans would be a thing of the past, like your obsolete student uniforms. You probably began your first nursing job, enthusiastic and ready to be a “real nurse.” What did you discover as you reviewed patient charts and Kardexes? Uh-oh! There it was again—the nursing care plan. As you cared for patients and worked with other nurses and health team members, you probably began to see the true value of nursing care plans in providing direction for your nursing care and in meeting the special needs of each individual patient.

Now, as you are preparing to return to nursing practice after an absence, you may wonder, “Are nursing care plans still a necessary part of patient care?” The answer to that is “Yes! More than ever!” With the increasing acuity of our patients, along with the shortage of nurses, care plans have become even more important. You will see that the planning process has been “refined” since your days in nursing school to make it easier to develop and implement nursing care plans. Standardized care plans, and in many settings computerized care plans, facilitate the care planning process and save valuable time that can be spent at the bedside.

#### **OVERVIEW**

Documenting the plan of care, or writing the nursing care plan, is the final step in the planning phase for the nursing process for the RN. Nursing care plans are written for individuals, families, groups, or communities. The purposes of the nursing care plan are:

- To provide a framework for nursing care
- To promote quality, client-centered care
- To promote continuity of care
- To provide for evaluation of the effectiveness of nursing care
- To promote communication among nursing staff and other health team members.

In essence, the nursing care plan is the blueprint for directing nursing activities, as written guideline for client care. The nursing care plan is the total plan which is needed to implement the nursing process from assessment through evaluation.

## **Why?**

Why must nursing care plans be written? With the many functions and responsibilities of the nurse, why must time be spent in documenting nursing care plan? In order for the nursing care plan to be effective, it must be documented. This documentation provides a mechanism for communication among health team members which can help to ensure consistent, coordinated, effective care for the client. By writing the care plan, a permanent record is made of the care the client should receive and what he or she actually has received. The nursing care plan, when properly written, should provide direction for the nurse in terms of the type and frequency of observations to be made, what nursing measures to implement and how often, as well as what to teach the client and family. The nursing care plan indicates what should be documented in the nurse's notes or progress notes. It also guides the nurse in evaluating the effectiveness of the care given to the client. Care plans facilitate nurses in delivering high-quality, consistent, and effective care.

## **Who?**

Who is responsible for formulating the nursing care plan? The American Nurses' Association, Joint Commission, and state nursing practice acts are specific regarding the role of the registered nurse in initiating the nursing care plan. The RN, due to her/his educational background, is considered the most qualified to begin developing the nursing care plan. It is not the responsibility or in the scope of practice for a LPN/LVN to initiate the care plan.

## **When?**

When should the care plan be developed? The most appropriate time is immediately after the first contact with the client. Once the assessment is completed and the data base has been reviewed, the registered nurse can begin to identify actual and potential problems (nursing diagnoses), and plan care accordingly. The initial nursing care plan will need to be revised and refined after further interactions with the client. While the registered nurse will begin to formulate the nursing care plan, other staff members will participate in evaluating and refining the care plan based on their assessments and identification of actual or potential problems.

It is essential that the nursing care plan be current. Updating the plan frequently (indicating resolved problems and adding newly-identified nursing diagnoses) will help to ensure appropriate, individualized care for the client.

## **Where?**

Nursing care plans should be readily available to all health team members involved in the care of the client. Access increases the use of the care plan. In some institutions, care plans are kept at the bedside; others keep the care plan in the chart or Kardex. Computerized facilities now keep the care plans in computerized medical charts.

Nursing care plans are useful not only within the client's current setting, but also as an important communication tool when clients are transferred from one department or unit to another, from one institution to another, or from an institution to home health care. The nursing care plan provides the essential ingredients for continuity of care.

The methods and format for writing nursing care plans vary according to the type of health care setting and the policies of that institution. For example, the nursing care plan for an acute care hospital will be different from the care plan for a community health agency.

The components of the written nursing care plan most frequently used are:

1. Nursing diagnosis
2. Goals or expected outcomes
3. Nursing actions or interventions
4. Evaluation

### **Standardized nursing care plans**

To facilitate the preparation and use of written nursing care plans, many institutions use standardized care plans. These care plans are often developed by the institution's staff based on medical and nursing literature as well as institutional policies and procedures. Some institutions choose to use nursing care plans derived directly from available reference books.

The advantages of standardized care plans are:

- They are developed by clinical experts and become the standards of care for clients with a particular diagnosis; thus, they can be used to educate nurses unfamiliar with certain medical or nursing diagnoses.
- They reduce the time nurses spend writing nursing care plans; thus, standardized care plans increase the efficiency of nursing care planning.

Standardized care plans are usually categorized according to specific medical-surgical conditions. (There are also standardized care plans for obstetrics, pediatrics, and other specialties.) Standardized care plan formats typically include nursing diagnoses, goals/expected outcomes, and nursing interventions. Because standardized care plans include the usual or predictable problems associated with the specific medical diagnoses, the plans must be individualized for each client.

### **Computerized nursing care plans**

We live in the age of computerization, and computers are integral to health care delivery. Many institutions now use computerized nursing care plans. These vary from care plans based on medical diagnoses to those based on nursing diagnoses to those developed individually for each client. Once the nursing assessment is completed, the standardized/computerized care plan, that is appropriate for the client, is decided upon. The nurse has to add or delete information on the generalized care plan to individualize it to the needs of the client. If this process fails, inaccurate and incomplete care will result.

### **Nursing Care Planning: The Process**

The ANA Standards of Nursing Practice will be used as the basis for review of nursing process. The discussion will focus on nursing care plans for the hospitalized client, as this will be most helpful to you in your clinical practicum and subsequent practice. A nursing care plan will be developed based on a given patient situation.

## Assessment

Standard I: The collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated, and recorded.

Before the nurse can develop the nursing care plan, there must be a data base from which to derive nursing diagnoses. Data collection begins with the nurse's first encounter with the patient and continues throughout the hospital stay. At the time of admission, a complete health history is done and physical assessment is performed. Pertinent data are recorded in the chart and in the nursing care plan. Subsequent assessments are done with each nurse/patient interaction. Continuing assessment is necessary to provide data for updating the care plan and meeting the ever-changing needs of the patient.

The three primary methods of collecting assessment data are:

- Interview
- Observation
- Physical examination

The primary source of information is the patient. Other sources are:

- Family
- Significant others
- Medical records
- Health team members

After assessment data is collected, it must be organized into a manageable format. The categories of the health history form can be utilized (e.g., respiratory status, health perception/health management). Another useful method is to organize the data according to Maslow's hierarchy of needs, which will also facilitate the prioritization of the patient's problems in the planning phase.

## Case Study

Mrs. Jones is a 32-year-old house wife, mother of two-year-old twin boys, who was admitted to the hospital yesterday with bilateral pneumonia.

- Vital signs: T-100.2 P-102 R-28 BP-110/60.
- IV D5 $\frac{1}{4}$ NS infusing at 100cc/hr.
- Appetite is poor; drinking only moderate amount of fluids.
- Auscultation of chest reveals bilateral crackles and wheezes.
- Frequent productive cough of thick yellow mucous.
- States she is very weak and tired because the cough has been keeping her awake at night and prevents her from sleeping in the daytime.
- States she gets "short of breath" with any activity.
- Her husband is home with the twins, and she is worried about him having to take care of the boys.

Categorizing the data: all of the assessment data are related to physiologic needs except for the last one, which is related to self-esteem (role change).

## Nursing diagnosis

Standard II. Nursing diagnoses are derived from health status data.

Nursing diagnoses are actual or potential problems, which the patient is experiencing or may experience that may be prevented, resolved, or reduced by nursing intervention. Nursing diagnoses describe human responses and alterations in the client's ability to function as an independent human being.

In North Carolina formulation of nursing diagnoses is a function that is the responsibility of the RN. The LPN assists the RN in this process through their participation in the collection and discussion of data.

To determine which problems should be addressed first, in the plan of care, the nursing diagnoses must be prioritized. This component of practice is reserved for the RN.

1. In setting priorities, the first consideration is: Are any of the identified nursing diagnoses life-threatening? In this patient situation, the answer is no.
2. The next step is to classify the diagnoses according to Maslow's hierarchy of needs. Remember, the physiological needs are essential for survival. In prioritizing physiological need, those diagnoses, which take highest priority to relate to the need for air and oxygen. After that, needs related to food, water, sleep, and comfort are addressed. Higher level needs, such as those related to self-esteem; take lower priority than physiological needs.

It is important to remember that lower level needs do not have to be completely resolved before progressing to higher level needs. Also, there can be unresolved needs on more than one level at the same time.

3. Scientific and nursing practice principles should be considered when prioritizing nursing diagnoses.
4. The patient's input is essential in prioritizing diagnoses and determining which problems should be addressed first. The nurse should focus first on problems the patient feels are most important as long as the priority does not interfere with medical treatment and is in the best interest of the patient.

## Case Study

In prioritizing nursing diagnoses for Mrs. Jones, we will assume that she is feeling very debilitated by her lack of sleep. Thus, after placing in highest priority the problems related to air and oxygen, the need for sleep becomes the next priority.

### Physiologic needs:

1. Ineffective breathing pattern related to weakness and fatigue.
2. Ineffective airway clearance related to thick secretions.
3. Disturbed sleep pattern related to frequent cough.
4. Alteration in nutrition-less than body requirements related to loss of appetite.
5. Deficient fluid volume related to loss of appetite and insufficient oral intake.
6. Activity intolerance related to weakness and fatigue.

Self-esteem need:

7. Anxiety related to change in role functioning associated with husband having to assume care of children.

**Goals/expected outcomes**

Standard III: The plan of nursing care includes goals derived from the nursing diagnosis. In North Carolina, setting goals and outcome criteria is a component of practice reserved for the RN. A goal or expected outcome statement describes client behaviors that would demonstrate a reduction, resolution, or prevention of a particular problem identified in the nursing diagnosis. Expected outcomes state what the client will be able to do, under which conditions, how well the client will perform, and when the client is to be evaluated. Goals are developed in collaboration with the patient and family/significant others with input from other members of the health care team.

Goals/expected outcome statements should be:

- Client-centered
- Measurable and observable
- Time-limited
- Reasonable and realistic
- Clearly stated

Goals/expected outcomes must be congruent with the response component of the nursing diagnosis statement. If not, the nursing diagnosis is not being used to guide care planning.

**Case Study**

For the nursing diagnoses, which were identified for Mrs. Jones, the goals/expected outcomes are:

**Nursing Diagnosis 1:** Ineffective breathing pattern related to weakness and fatigue.

**Expected Outcome:** The patient will experience adequate respiratory function within 48 hours as evidenced by:

- a. Respiratory rate 12-18 min.
- b. Decreased dyspnea
- c. Lungs clear to auscultation
- d. No cyanosis
- e. Clear mental status
- f. Blood gases within normal limits

**Nursing Diagnosis 2:** Ineffective airway clearance related to thick secretions.

**Expected Outcome:** The patient will maintain patent airways during hospitalization as evidenced by:

- a. Lung sounds are clear to auscultation bilaterally
- b. Chest x-ray results within normal limits
- c. Ability to expectorate secretions effectively
- d. Respiratory rate 12-18 min.

- e. No cyanosis
- f. Clear mental status
- g. Blood gases within normal limits

**Nursing Diagnosis 3:** Disturbed sleep pattern related to frequent cough.

**Expected Outcome:** The patient will sleep as much as possible within the parameters of the treatment plan during hospitalization as evidenced by:

- a. The patient will sleep 3-4 hours at a time
- b. The patient states she feels “rested”
- c. No signs of sleep deprivation (difficulty concentrating, thick speech, irritability, inappropriate behavior.)
- d. Decreased coughing episodes

**Nursing Diagnosis 4:** Alternation in nutrition—less than body requirements related to loss of appetite.

**Expected Outcome:** The patient will resume an adequate nutritional intake prior to discharge as evidenced by:

- a. No further weight loss while in the hospital
- b. Patient eats three meals and two snacks per day
- c. Patient states she feels hungry at mealtime
- d. Patient states importance of nutritionally sound diet

**Nursing Diagnosis 5:** Deficient Fluid volume relate to loss of appetite and insufficient oral intake.

**Expected Outcome:** The patient will resume adequate fluid intake within two days as evidenced by:

- a. Normal skin turgor
- b. Mucous membranes moist
- c. Vital signs within normal limits and stable with position change
- d. Electrolytes, hemoglobin, hematocrit within normal limits
- e. Urine specific gravity 1.010-1.025
- f. Balanced intake and output
- g. Fluid intake of 2500-3000cc/day

**Nursing Diagnosis 6:** Activity intolerance related to weakness and fatigue.

**Expected Outcome:** The patient will demonstrate an increased tolerance for activity by discharge as evidenced by:

- a. The ability to resume activities of daily living without undue fatigue or dyspnea
- b. Alternating activity with rest periods
- c. Patient states she is less fatigued with activity

**Nursing Diagnosis 7:** Anxiety related to change in role functioning associated with husband having to assume care of children.

**Expected Outcome:** The patient will experience a reduction in anxiety during hospitalization as evidenced by:

- a. Patient verbalizes feelings and concerns
- b. Patient states she feels less anxious
- c. Relaxed facial expression and body movements

NOTE: All of the above diagnoses include the phrase “as evidenced by” to indicate the measurable behaviors which are the expected outcomes.

### **Nursing Intervention/Implementation**

Standard 4: The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnosis.

Nursing interventions are based on the nursing diagnoses and identified goals/expected outcomes. Nursing interventions identify what the nurse is to do to reduce, resolve, or prevent each of the problems expressed in the nursing diagnoses. It is necessary that the interventions be individualized to meet the total biopsychosocial needs of the patient. All nursing interventions need to be documented in the care plan.

It is important to remember that nursing actions should be:

1. Safe for the patient
2. Based on scientific rationale
3. Stated clearly and concisely
4. Realistic for the patient, nurse, and resources available
5. Congruent with other therapies the patient is receiving.

Standard 5: Nursing actions provide for client/patient participation in health promotion, maintenance, and restoration.

As in all phases of the nursing process, it is important to include the patient and family or significant others in the process of planning and implementing appropriate nursing actions.

Standard 6: Nursing actions assist the client/patient to maximize his capabilities.

Through nursing interventions, the patient is assisted in attaining the optimal level of functioning based on his health status and limitations.

In planning nursing actions, it is important to include specific interventions related to assessment of the patient, performance of specific nursing measures, and patient/family teaching. For most nursing diagnoses, all three types of nursing actions should be incorporated in the plan of care. In North Carolina, developing a plan of care, which includes determining and prioritizing nursing interventions and identifying resources based on necessity and availability is a component of practice reserved for the RN. The LPN, however, assists in the identification of nursing activities that constitute the delivery of nursing care and participants in the delivery of care as delegated by the RN.

### **Case Study**

For three of the identified nursing diagnoses for Mrs. Jones, appropriate nursing actions are stated:

Nursing Diagnosis 1: Ineffective breathing patterns related to weakness and fatigue.

**Expected Outcome:** The patient will experience adequate respiratory function within 48 hours as evidenced by:

- a. Respiratory rate 12-18 min.
- b. Decreased dyspnea
- c. Lungs clear to auscultation
- d. No cyanosis
- e. Clear mental status
- f. Blood gases within normal limits

**Nursing Actions:**

1. Assess and document vital signs including respiratory rate every four hours and prn.
2. Assess and document lung sounds every four hours and prn.
3. Assess and document signs of hypoxia every four hours and prn (color, dyspnea).
4. Monitor blood gases as ordered, report abnormal results to physician.
5. Elevate head of bed 45 degrees as tolerated.
6. Instruct and assist patient to turn, cough, and deep breathe every 1-2 hours.
7. Encourage use of incentive spirometer every 1-2 hours.
8. Perform actions to promote removal of pulmonary secretions:
  - Fluid intake of 2500-3000cc per day
  - Humidify inspired air as ordered
  - Assist with or perform chest physiotherapy as ordered
  - Administer expectorants as ordered and monitor effects
9. Administer oxygen prn as ordered.
10. Provide psychosocial support and restful environment.
11. Notify physician if impaired breathing pattern persists or worsens.

**Nursing Diagnosis 5:** Deficient fluid volume related to loss of appetite and insufficient oral intake.

**Expected Outcomes:** The patient will resume adequate fluid intake within two days as evidenced by:

- a. Normal skin turgor
- b. Moist mucous membranes
- c. Vital signs within normal limits and stable with position change
- d. Electrolytes, hemoglobin, and hematocrit within normal limits
- e. Urine specific gravity 1.010-1.025
- f. Balanced intake and output
- g. Fluid intake of 2500-3000cc/day

**Nursing Actions**

1. Assess and document skin turgor and mucous membranes every shift and prn.
2. Assess and document vital signs every four hours and prn. Check postural pulses every shift.
3. Monitor results of blood work, especially Na<sup>+</sup>, K<sup>+</sup>, Cl<sup>-</sup>, BUN, creatinine, H&H.
4. Monitor and record accurate intake and output.
5. Measure urine specific gravity q shift and document

6. Encourage oral fluid intake. Teach patient the importance of adequate intake.
7. Offer fluid of patient's choice at bedside.
8. Instruct patient to inform nurse of thirst.

**Nursing Diagnosis 7:** Anxiety related to change in role functioning associated with husband having to assume care of children.

**Expected Outcomes:** The patient will experience a reduction in anxiety during hospitalization as evidenced by:

1. Patient verbalizes feelings and concerns
2. Patient states she feels less anxious
3. Relaxed facial expression and body movements

#### **Nursing Actions:**

1. Assess and document level of anxiety every shift.
2. Encourage patient to express feelings and concerns to externalize anxiety.
3. Help patient identify sources of anxiety in the past.
4. Explore with patient techniques, which have been effective in reducing anxiety in the past.
5. Reassure patient during interactions by touch and empathetic verbal and nonverbal communications. Allow patient to cry.
6. Provide quiet environment without excessive stimulation.
7. Provide diversional activity such as books, television, and radio.
8. Provide positive reinforcement when patient is able to continue with activities of daily living and focus on progressing toward wellness.

#### **Implementation of care**

Prior to implementing the planned nursing interventions, the nurse should reassess the patient to determine if there have been any changes since the plan was formulated. The nurse must understand the rationale, technique, and possible effects of each nursing action.

During delivery of care, patient safety is of utmost importance. The care is individualized to meet the needs of each patient. Patient participation is encouraged during implementation of nursing actions.

Assessment of the patient during implementation of care provides needed data for evaluation. Patient responses to care are documented along with the specific measures, which were implemented.

#### **Documentation of care**

As a final step in implementation, the nurse documents care given to the patient. The old saying, "if it is not recorded it has not been done" guides the nurse in determining what should be documented. If evidence of documentation is omitted from the patient's permanent record, it would seem that the plan of care was not followed and the efforts of the nurse were wasted. Accurate and completed documentation of patient care is a legal requirement in all health care settings.

#### **Evaluation**

Standard 7: The client/patient's progress or lack of progress toward goal achievement is determined by the client/patient and the nurse.

The patient's role in the nursing process is never more important than in the evaluation process. The nurse can assess through objective data whether or not the nursing actions were effective. The patient provides necessary subjective data regarding the effectiveness of the plan of care. After all, it is the patient's problem that is being addressed, and his or her perception of goal achievement is key to evaluation.

Through evaluation the nurse determines the patient's progress toward achievement of the stated goals/expected outcomes. The focus of goal evaluation is the outcome of nursing care in the form of changed client behavior.

1. When evaluating goal achievement for a particular nursing diagnosis, the nurse examines the goal/expected outcome statement in the nursing care plan:
2. What was the expected client behavior?
3. Was the client able to perform the expected behavior in the time specified in the goal statement?
4. Was the client able to perform the behavior as well as described in the expected outcome statement?

When the goals are evaluated, they should be signed and dated by the nurse. It should be indicated whether the goal was resolved, partially resolved, or not resolved at all.

Standard 8: The client/patient's progress or lack of progress toward goal achievement directs reassessment, reordering of priorities, new goal setting, and revision of the plan of nursing care, by the RN. It is within the components of the North Carolina Nurse Practice Act for the LPNs to recognize the effectiveness of nursing interventions and to propose modifications to the plan of care for review by the RN.

Following evaluation of goal achievement, the RN reviews the entire nursing care plan, judging the effectiveness of the nursing actions, strategies, and the plan of care. This review of the care plan keeps it current and responsive to the patient's changing needs.

**Review of the nursing care plan = reassessment = re-planning = review of implementation.**

During reassessment, the nurse examines previously-gathered data to determine if it is still representative of the patient's status. New data, which was collected during implementation of care, is also examined. New nursing diagnoses are formulated and previously identified diagnoses are deleted or revised by the RN.

With re-planning, priorities are evaluated and nursing diagnoses are reordered as needed based on current data. Previously-identified goals and outcomes are examined to determine their appropriateness, while new goals are developed for the newly-identified nursing diagnoses. Nursing interventions are also examined to determine whether they should be continued, changed or revised based on the patient's current status. Interventions are planned for the newly-identified diagnoses.

During review of implementation, the nurse examines what actually occurred with the patient as he or she received nursing care. This is important as it may point out problems that can be corrected when the nursing care plan is revised. The nurse considers such questions as:

- Were the interventions realistic in terms of time and resources?
- Were the interventions appropriate for the nursing diagnosis?
- Who actually carried out the nursing interventions?
- Were the nursing actions vague or misinterpreted?
- Did the nurse's personal feelings affect the delivery of care?
- Was the nurse sufficiently skilled and knowledgeable in the delivery of care?

This review of the actual care given is especially important when the stated goals were not achieved.

When the nurse completes the review of the nursing care plan, the result is an updated plan for nursing care, which is then implemented and evaluated. Review of the nursing care plan begins once again, and so the process continues until all problems are resolved or the patient is discharged to home or transferred to another health care setting.

### Case Study

The following is an example of evaluation as part of the nursing care plan for Mrs. Jones:

**Nursing Diagnosis 5:** Deficient fluid volume related to loss of appetite and insufficient oral intake.

**Expected Outcomes:** The patient will resume adequate fluid intake within two days as evidenced by:

- a. Normal skin turgor
- b. Moist mucous membranes
- c. Vital signs within normal limits and stable with position change
- d. Electrolytes, hemoglobin, and hematocrit within normal limits
- e. Urine specific gravity 1.010-1.025
- f. Balanced intake and output
- g. Fluid intake of 2500-3000cc/day

**Evaluation:** At the end of two days:

- Normal skin turgor
- Mucous membranes are moist
- BP 11/60-144/64, P 68-72 R 18-20. No postural hypotension
- Blood work WNL
- Specific gravity 1.019 - 1.021
- Intake 2500cc/day, output 2000cc/day
- Mrs. Jones is drinking fluids independently and states the importance of adequate fluid intake.

**Problem is resolved; goal was achieved.**

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### EVALUATION

1. Did this module cover what you expected it to? Yes\_\_\_
2. Was the topic treated in sufficient depth? Yes\_\_\_  
No\_\_\_  
If no, check one of the following: Too little depth\_\_\_  
Too great a depth\_\_\_  
Assumed I know too much\_\_\_
3. Did the module hold your interest? Yes\_\_\_  
No\_\_\_
4. Were the objectives fulfilled? Yes, very much\_\_\_  
Somewhat\_\_\_  
Very little\_\_\_
5. Was the module written in easily understood language? Yes\_\_\_  
No\_\_\_
6. Estimate the number of hours you spent reading and studying this module. 1-5hrs. \_\_\_  
6-10 hrs. \_\_\_  
11-20 hrs. \_\_\_  
More than 20 hrs. \_\_\_
7. Will you be able to use this information when you return to practice? Yes\_\_\_  
No\_\_\_
8. Overall, were you satisfied with the module? Yes\_\_\_  
No\_\_\_
9. Please use the space below (and on the back, if needed) to offer additional comments or suggestions.  
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10. Module #\_\_\_