Guidelines for Writing Satisfactory Nursing Care Plans

References: Use the same references used in Nursing 110, and 111. Other references that are considered professional for nursing may be used.

Diagnosis/Definition
Define the current diagnosis. Include common etiology, signs and symptoms and standard treatment(s). This information will come from a reference and may not be exactly what your client is experiencing.

Surgical Procedures
This area refers to surgery or procedures your client received during this hospital visit. Give a definition and an explanation of the surgical procedure. Previous surgeries should be listed under Pertinent Past Medical History.

Pertinent Past Medical & Social History
Include medical history of client and blood relatives if pertinent. Also, describe lifestyle habits (such as smoking). Social history includes who the client resides with, type of work client does/did and ability to afford health care.

Cultural & Religious Considerations
Explain how nursing care might be impacted by the client’s culture and/or religion. This information may come from a reference and give general guidelines about culture and religion’s affect on client care. Often included areas are food, language, and family closeness. Compare differences you may see in your actual client and the reference.

Developmental Stage
Using one of the developmental theorist, identify characteristics of the developmental stage of your client and explain how your client compares. Give rational and examples for your answer.

Diagnostic Test Page
A. List the diagnostic tests that are abnormal and fit with your patient’s medical diagnosis. Include normal values and the patient's results
B. Research each lab value separately (i.e., Hct, Hgb, WBC, etc) and explain how it relate to diagnosis column.
   1. Explain implications of results.
   2. Attempt to explain purpose of test compared to medical diagnosis.
   3. References for this information must be included.
   4. Explain nursing action and preparation for the test. Include patient teaching.
C. Circle or highlight all abnormal values and attempt to relate them to the patient's condition include references.
D. Remember that x-rays, CT scans, and EKG’s are examples of diagnostic tests.

Medications
A. Include all medications.
B. Identify purpose of medication, patient teaching, and relate it to medical condition.
C. Describe nursing actions needed to administer each medication safely. This might include taking VS’s or checking lab values.
D. References are to be included for each medication.
E. list IV fluids and IV medications.
F. Oxygen is a medication.
Data Collection
A. Subjective Data must be included which support the nursing diagnosis (or the statement "none").
B. Objective Data must be included which support the nursing diagnosis (or the statement "none").
C. There must be some data.

Nursing Diagnosis
A. Actual nursing diagnosis is a three part statement (problem R/T etiology as evidenced by S&S present).
B. Potential nursing diagnosis is a two part statement (potential problem R/T) etiology).
C. Should be from NANDA approved list if possible.
D. Must be prioritized according to Maslow's hierarchy of human needs if there is more than one nursing diagnosis.
E. There must be at least four nursing diagnoses.
   1. Generic Nursing Diagnoses/Plans can be used for one nursing diagnosis.
F. One nursing diagnosis per page with its goal and nursing interventions

Patient Goals
A. Must be written in terms of client behavior.
B. Goals need to be measurable.
C. Goals need to have a time element.
D. Goals should be realistic for the client and the student.
E. Goals need to relate to the nursing diagnosis.
F. Goals should be short-term in nature for Nursing 112.

Nursing Action/Implementation
A. First action should be to assess for the identified problem.
B. Actions need to include time parameters.
C. Actions include physician's orders as well as actions by ancillary health care personnel (respiratory therapy, physical therapy, dietician, lab, X-ray).
D. Actions include applicable medications-administration of and monitoring for effects.
E. Actions are appropriate for developmental stage.
F. Actions allow for cultural and religious consideration.
G. Actions include patient teaching.

Rationale (Purpose, Objective, "Why")
A. Each action has a rationale.
B. Each rationale has a reference.

Evaluation
A. Includes a goal statement (goal met, goal partially met, goal not met).
B. Identifies client behavior(s) that validate(s) the goal statement.
C. If the goal was not met or only partially met, attempt to determine the reason.
D. Refers to client goal not nursing actions.

Reassessment
A. Identify which problems have been resolved or are ongoing.
B. Identify which interventions (if any) should be modified.
C. Identify how the goal should be changed (if necessary).

Mini Care Plans
A. Include mini care plans with each care plan.