NURSING CARE PLAN ASSIGNMENT

Overview

Each student is required to complete a client care plan for one client cared for during the preceptorship. This assignment includes preparing extensive data (including CTW) and a nursing care plan. In choosing your NCP client, keep in mind:

- Choose a client at the appropriate level of complexity for a Quarter 6 student. This is one of the primary methods that your nursing instructor has of assessing where your nursing judgment is. Consult with your clinical instructor if you have questions. And, yes, it must be a client YOU cared for.
- Complete the typewritten NCP paper (with the 4 basic areas discussed in the following section of this syllabus) and submit to instructor
- No hospital documents of any kind nor any Xerox copies of any hospital records is allowed (per HIPAA and most hospital polices). IT IS acceptable to transcribe data (eg. Serial ABGs, lab data, etc) and create a table or spreadsheet.
- DO NOT use any of the following on your NCP: client name or initials, room number, dates of care, or hospital name (your instructor knows where you are precepting).
- DO state clients age and gender, and refer to the client as “Mr. Jones” or some made-up name (introduce as such in the opening section of the NCP). For dates of care, simply state “Day #1, Day #2, etc”.

NCP Paper:

There are 4 basic areas of information to be included in the NCP paper:

1. Detailed background information
2. Critical thinking worksheet (CTW)
3. One, 5-column care plan for each of your top 3 priority nursing diagnoses
4. Cultural aspects of care

This paper is to be typewritten, including all 4 sections (above), and is to be handed to the CLINICAL instructor on the due date according to the class calendar. The following pages provide a template and detailed instructions for Sections 1, 2, and 4 of the “4 basic areas” required in the NCP Paper to be handed in. Section 3 is the “Care Plan” and should be written in a similar manner to previous quarters in the nursing program with the following exception: rationale must be DOCUMENTED (eg. written: give reason you are employing the intervention) but NOT referenced (you DO NOT need to quote someone). Please complete the care plan section for the top 3 ACTUAL NURSING DIAGNOSES. Exception: if you believe that one of your high priority “Risk For” nursing diagnoses ranks higher in importance than one of the top 3 Actual diagnoses, you may complete the care plan on the Risk For diagnoses in lieu of one of the Actual ones. Please provide your rationale and supporting data (eg. assessment data, etc.) if this is the case

SECTION 1: DETAILED BACKGROUND INFORMATION

Please prepare your NCP paper using the following guide (headings in CAPS).

Student Name: ____
Client Gender: ____
Age____
Admitting Diagnosis: ____
Other Diagnosis: ____

1. BRIEF HISTORY OF CURRENT HOSPITAL STAY. General overview of your client's current hospital stay, including how long ago s/he was admitted, initial and any subsequent diagnoses, complications, diagnostic tests, pertinent lab tests, etc.

2. PATHOPHYSIOLOGY OF DISEASE PROCESS. An explanation of the pathophysiology of your client's primary medical diagnosis. If your client has multiple diagnoses, describe how they all come into play with the current hospitalization, emphasizing the most pertinent diagnoses. Identify signs and symptoms you observe in your client that relate to the pathophysiology you are discussing.

3. MEDICATIONS. List all scheduled medications (dose, route, frequency) and all PRN medications given within the last 48 hours. Next to each drug, state the action of the drugs, the rationale for your client receiving it, and if the dosage is appropriate considering your client's age and diagnoses.

4. INTERACTIONS AND SPECIAL CONSIDERATIONS. Of the medications listed above, what potential drug interactions and special considerations can you identify? Consider COMMON side effects, side effects in light of your client's diagnoses, age, and previous health history. DO NOT list every possible side effect of drug interaction, but rather a SYNTHESIS of those pertinent to your client.

5. LABORATORY DATA. List and describe all recent lab data on your client. On abnormal results, describe what these results might indicate (consult the Laboratory and Diagnostics reference book required for the course). DO NOT list out every possible medical diagnosis. DO list what might be realistically attributable to your client. Don't forget to include fingerstick values.

6. DIAGNOSTIC TESTS. Describe the results of all recent diagnostic tests. On abnormal results, describe what these results might indicate (again, consult the Laboratory and Diagnostics text).

SECTION 2: CRITICAL THINKING WORKSHEET

ASSESSMENT DATA: Instructions (Universal SCRs – first 7 sections**)

1. Document basic assessment data according to Orem.
2. Document comprehensive assessment data *** according to Orem.
3. Write the rationale(s) for performing the assessment.
4. Nursing diagnos**es***** (3 part – note there are often more than one per Orem category).
5. Modify plan of care by synthesizing data and predicting possible outcomes

AIR

1.
***2.
3.
4.
***5.

WATER

1.
***2.
3.
4.
***5.

FOOD

1.
***2.
3.
4.
***5.

ACTIVITY AND REST

1.
***2.
3.
4.
***5.

ELIMINATION

1.
***2.
3.
4.
***5.

**Don't forget VS, I&O, IVs (rate, solution, etc), oxygen and other "attachments" such as drainage devices, etc. Also briefly recap results of pertinent lab data and diagnostic tests under the appropriate categories.

***Scope of practice: not required by the LVN

SOLITUDE AND SOCIAL INTERACTION

1.
***2.
3.
4.
***5.

PREVENTION OF HAZARDS

1.
***2.
3.
4.
***5.

DEVELOPMENTAL SELF-CARE REQUISITES

Consult your medical-surgical text, or any other psychology text that defines the level at which your client is currently functioning. Identify the client's level using an adult developmental theory of your choice. This section should also include answers to some of the following questions:

- Who does the client live with?
- What are the client's responsibilities at home?
- What is (was) the client's occupation?
- What is the client's educational level?
- Are other issues (eg. insurance) which affect this client's health status directly or indirectly?
- What support systems exist at home for the client?
- How does the client's religion affect his/her health status?
- How will the client's developmental level affect his/her recover, discharge planning and future prognosis?

HEALTH DEVIATION SELF-CARE REQUISITES

For this section, proved your **PRIORITIZED NANDA LISTS** using 3 part nursing diagnosis. Please rank in priority each and every nursing diagnosis! I would like to see 2 lists – one list of actual Nursing Diagnoses, and one list for "Risk for" Nursing Diagnoses:

ACTUAL	RISK FOR

SECTION 4: CULTURAL ASPECTS OF CARE

(Minimum 2 paragraphs, must include 1 or more references)

Provide a written narrative describing the cultural aspects of your client's situation that influenced your nursing care of the client and his or her hospital stay. Include ethnicity, family interactions/behaviors, "hospital culture", desire for/use of alternative therapies and their potential interactions with medical therapies, etc.