EDITION 8

Nursing Care Plans

Guidelines for Individualizing Client Care Across the Life Span

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Mary Frances Moorhouse
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- All Medical/Surgical care plans from the book
- 50 Maternal/Newborn care plans
- 35 Psychiatric care plans
- Pediatric Considerations
- The top 400 Health Conditions

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KEY TO ESSENTIAL TERMINOLOGY

Client Assessment Database

Provides an overview of the more commonly occurring etiology and coexisting factors associated with a specific medical and/or surgical diagnosis as well as the signs and symptoms and corresponding diagnostic findings.

Nursing Priorities

Establishes a general ranking of needs and concerns on which the Nursing Diagnoses are ordered in constructing the plan of care. This ranking would be altered according to the individual client situation.

Discharge Goals

Identifies generalized statements that could be developed into short-term and intermediate goals to be achieved by the client before being "discharged" from nursing care. They may also provide guidance for creating long-term goals for the client to work on after discharge.

Nursing Diagnosis

The general need or problem (diagnosis) is stated without the distinct cause and signs and symptoms, which would be added to create a client diagnostic statement when specific client information is available. For example, when a client displays increased tension, apprehension, quivering voice, and focus on self, the nursing diagnosis of Anxiety might be stated: severe Anxiety related to unconscious conflict, threat to self-concept as evidenced by statements of increased tension, apprehension; observations of quivering voice, focus on self.

In addition, diagnoses identified within these guides for planning care as actual or risk can be changed or deleted and new diagnoses added, depending entirely on the specific client information.

May Be Related to/Possibly Evidenced by

These lists provide the usual or common reasons (etiology) why a particular need or problem may occur with probable signs and symptoms, which would be used to create the "related to" and "evidenced by" portions of the *client diagnostic statement* when the specific situation is known.

When a risk diagnosis has been identified, signs and symptoms have not yet developed and therefore are not included in the nursing diagnosis statement. However, interventions are provided to prevent progression to an actual problem. The exception to this occurs in the nursing diagnosis risk for Violence, which has possible indicators that reflect the client's risk status.

Desired Outcomes/Evaluation Criteria—Client Will

These give direction to client care as they identify what the client or nurse hopes to achieve. They are stated in general terms to permit the practitioner to modify or individualize them by adding time lines and specific client criteria so they become "measurable." For example, "Client will appear relaxed and report anxiety is reduced to a manageable level within 24 hours."

Nursing Outcomes Classification (NOC) labels are also included. The outcome label is selected from a standardized nursing language and serves as a general header for the outcome indicators that follow.

Actions/Interventions

Nursing Interventions Classification (NIC) labels are drawn from a standardized nursing language and serve as a general header for the nursing actions that follow.

Nursing actions are divided into independent—those actions that the nurse performs autonomously; and collaborative—those actions that the nurse performs in conjunction with others, such as implementing physician orders. The interventions in this book are generally ranked from most to least common. When creating the individual plan of care, interventions would normally be ranked to reflect the client's specific needs and situation. In addition, the division of independent and collaborative is arbitrary and is actually dependent on the individual nurse's capabilities and hospital and community standards.

Rationale

Although not commonly appearing in client plans of care, rationale has been included here to provide a pathophysiological basis to assist the nurse in deciding about the relevance of a specific intervention for an individual client situation.

Clinical Pathway

This abbreviated plan of care or care map is event- or task-oriented and provides outcome-based guidelines for goal achievement within a designated length of stay. Several samples have been included to demonstrate alternative planning formats.

NURSING DIAGNOSES ACCEPTED FOR USE AND RESEARCH FOR 2009–2011

Activity Intolerance [specify level]
Activity Intolerance, risk for
Activity Planning, ineffective
Airway Clearance, ineffective
Allergy Response, latex
Allergy Response, risk for latex
Anxiety [specify level]
Anxiety, death
Aspiration, risk for
Attachment, risk for impaired
Autonomic Dysreflexia
Autonomic Dysreflexia, risk for
Behavior, risk-prone health
Bleeding, risk for
Body Image, disturbed
Body Temperature, risk for imbalanced
Bowel Incontinence
Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Breathing Pattern, ineffective
Cardiac Output, decreased
Caregiver Role Strain
Caregiver Role Strain, risk for
Childbearing Process, readiness for enhanced
Comfort, impaired
Comfort, readiness for enhanced
Communication, impaired verbal
Communication, readiness for enhanced
Conflict, decisional
Conflict, parental role
Confusion, acute
Confusion, risk for acute
Confusion, chronic
Constipation
Constipation, perceived
Constipation, risk for
Contamination
Contamination, risk for
Coping, defensive
Coping, ineffective
Coping, readiness for enhanced
Coping, ineffective community
Coping, readiness for enhanced community
Coping, compromised family
Coping, disabled family
Coping, readiness for enhanced family
Death Syndrome, risk for sudden infant
Decision-Making, readiness for enhanced
Denial, ineffective
Dentition, impaired
Development, risk for delayed
Diarrhea
Dignity, risk for compromised human
Distress, moral
Disuse Syndrome, risk for
Diversional Activity, deficient
Electrolyte Imbalance, risk for
Energy Field, disturbed
Environmental Interpretation Syndrome, impaired
Failure to Thrive, adult
Falls, risk for
Family Processes, dysfunctional
Family Processes, interrupted
Family Processes, readiness for enhanced
Fatigue
Fear
Feeding Pattern, ineffective infant
Fluid Balance, readiness for enhanced
[Fluid Volume, deficient hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced
Gas Exchange, impaired
Glucose Level, risk for unstable blood
Grieving
Grieving, complicated
Grieving, risk for complicated
Growth, risk for disproportionate
Growth and Development, delayed
Health Maintenance, ineffective
Health Management, ineffective self [formerly Therapeutic Regimen Management, ineffective]
Health Management, readiness for enhanced self [formerly Therapeutic Regimen Management, readiness for enhanced]
Home Maintenance, impaired
Hope, readiness for enhanced
Hopelessness
Hyperthermia
Hypothermia
Identity, disturbed personal
Immunization Status, readiness for enhanced
Infant Behavior, disorganized
Infant Behavior, readiness for enhanced organized
Infant Behavior, risk for disorganized
Infection, risk for
Injury, risk for
Injury, risk for perioperative positioning
Insomnia
Intracranial Adaptive Capacity, decreased
Jaundice, neonatal
Knowledge, deficient [Learning Need] [specify]
Knowledge [specify], readiness for enhanced
Lifestyle, sedentary
Liver Function, risk for impaired
Loneliness, risk for
Maternal/Fetal Dyad, risk for disturbed
Memory, impaired
Mobility, impaired bed
Mobility, impaired physical
Mobility, impaired wheelchair
Motility, dysfunctional gastointestinal
Motility, risk for dysfunctional gastointestinal
Nausea
Neglect, self
Neglect, unilateral
Noncompliance [Adherence, ineffective] [specify]
Nutrition: less than body requirements, imbalanced
Nutrition: more than body requirements, imbalanced
Nutrition: more than body requirements, risk for imbalanced
Nutrition, readiness for enhanced
Oral Mucous Membrane, impaired
Pain, acute
Pain, chronic
Parenting, impaired
Parenting, readiness for enhanced
Parenting, risk for impaired
Perfusion, ineffective peripheral tissue
Perfusion, risk for decreased cardiac tissue
Perfusion, risk for ineffective cerebral tisse
Perfusion, risk for ineffective gastrointestinal
Perfusion, risk for ineffective renal
Peripheral Neurovascular Dysfunction, risk for
Poisoning, risk for
Post-Trauma Syndrome [specify stage]
Post-Trauma Syndrome, risk for
Power, readiness for enhanced
Powerlessness [specify level]
Powerlessness, risk for
Protection, ineffective
Rape-Trauma Syndrome
(Rape-Trauma Syndrome: compound reaction—retired 2009)
(Rape-Trauma Syndrome: silent reaction—retired 2009)
Relationship, readiness for enhanced
Religiosity, impaired
Religiosity, risk for impaired
Religiosity, readiness for enhanced
Relocation Stress Syndrome
Relocation Stress Syndrome, risk for
Resilience, impaired individual
Resilience, readiness for enhanced
Resilience, risk for compromised
Role Performance, ineffective
Self-Care, readiness for enhanced
Self-Care Deficit: bathing
Self-Care Deficit: dressing
Self-Care Deficit: feeding
Self-Care Deficit: toileting
Self-Concept, readiness for enhanced
Self-Esteem, chronic low
Self-Esteem, situational low
Self-Esteem, risk for situational low
Self-Mutilation
Self-Mutilation, risk for
Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Sexual Dysfunction
Sexuality Pattern, ineffective
Shock, risk for
Skin Integrity, impaired
Skin Integrity, risk for impaired
Sleep, readiness for enhanced
Sleep Deprivation
Sleep Pattern, disturbed
Social Interaction, impaired
Social Isolation
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-Being, readiness for enhanced
Stress Overload
Suffocation, risk for
Suicide, risk for
Surgical Recovery, delayed
Swallowing, impaired
(Therapeutic Regimen Management, effective—retired 2009)
(Therapeutic Regimen Management, ineffective community—retired 2009)
Therapeutic Regimen Management, ineffective family
Thermoregulation, ineffective
(Thought Processes, disturbed—retired 2009)
Tissue Integrity, impaired
Transfer Ability, impaired
Trauma, risk for
Trauma, risk for vascular
Urinary Elimination, impaired
Urinary Elimination, readiness for enhanced
Urinary Incontinence, functional
Urinary Incontinence, overflow
Urinary Incontinence, reflex
Urinary Incontinence, stress
(Urinary Incontinence, total—retired 2009)
Urinary Incontinence, urge
Urinary Incontinence, risk for urge
Urinary Retention [acute/chronic]
Ventilation, impaired spontaneous
Ventilatory Weaning Response, dysfunctional
Violence, [actual/]risk for other-directed
Violence, [actual/]risk for self-directed
Walking, impaired
Wandering [specify sporadic or continual]
[ ] author recommendations

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To the nurses we are writing for, who daily face the challenge of caring for the acutely ill client and are looking for a practical way to organize and document this care. We believe that nursing diagnosis and these guides will help.

To NANDA and to the international nurses who are developing and using nursing diagnoses—here we come!

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INTRODUCTION

We are often asked how we came to write the Care Plan books. In the late 1970s we were involved with some publishing efforts that did not come to fruition. In this work we had included care plans, so ensuing discussions revolved around the need for a Care Plan book. We spent a year struggling to write care plans before we realized our major difficulty was the lack of standardized labels for client problems. At that time, we were given a list of nursing diagnoses from the Clearinghouse for Nursing Diagnosis, which became the North American Nursing Diagnosis Association (NANDA), and is now NANDA International (NANDA-I). This work answered our need by providing concise titles that could be used in various plans of care and followed across the spectrum of client care. We believed these nursing diagnosis labels would both define and focus nursing care.

Because we had long been involved in direct client care in our nursing careers, we knew there was a need for guidelines to assist nurses in planning care. As we began to write, our focus was the nurse in a small rural community who at 2 a.m. needed the answer to a burning question for her client and had few resources available. We believed the book would give definition and direction to the development and use of individualized nursing care. Thus, in the first edition, the theory of nursing process, diagnosis, and intervention was brought to the clinical setting for implementation by the nurse. We also anticipated that nursing students would appreciate having access to these guidelines as they struggled to learn how to provide nursing care. Therefore, we did not consider the book to be an end in itself, but rather a vehicle for the continuing growth and development of the profession. Obviously we struck a chord and met a need because the first edition was an immediate success.

In becoming involved with NANDA, we acknowledged that maintaining a strict adherence to their wording, while adding our own clearly identified recommendations, would help develop this neophyte standardized language and would promote the growth of nursing as a profession. We have continued our involvement with NANDA-I, promoting the use of the language by practicing nurses in the United States and around the world and encouraging them to participate in updating and refining the diagnoses. The wide use of our books within the student population has supported and fostered the acceptance of both the activity of diagnosing client problems or needs and the use of standardized language.

Nursing instructors initially expressed concern that students would simply copy the plans of care and thus limit their learning. However, as students used the plans to individualize care and to develop practice priorities and client care outcomes, the book met with more acceptance. Instructors began not only to recommend the book, but also to adopt it as an adjunct text. Today, it remains the best-selling nursing care plan book recognized as an important adjunct for student learning.

In writing the second edition, we recognized the need for an assessment tool with a nursing focus instead of a medical focus. Not finding one that met our needs, we constructed our own. To facilitate problem identification, we categorized the nursing diagnosis labels and the information obtained in the client assessment database into a framework entitled "Diagnostic Divisions." Our philosophy is to provide a way in which to gather information and to intervene beneficially, while thinking about the rationale for every action we take and the standardized language that best expresses it. When nurses do this they are defining their practice and are able to identify it with a code and charge for it. By doing this, we promote client protection (quality of care issue), provide for the definition and protection of nursing practice, and the protection of the individual (legal implications). The latter is important because we live in a litigation-minded society and the nurse's license and livelihood are at stake.

One of the most significant achievements in the healthcare field over the past 20 or more years has been the emergence of the nurse as an active coordinator and initiator of client care. Although the transition from physician's helpmate to healthcare professional has been painfully slow and is not yet complete, the importance of the nurse within the system can no longer be denied or ignored. Today's nurse designs nursing care interventions that move the total client toward improved health and maximum independence.

Professional care standards and healthcare providers and consumers will continue to increase the expectations for nurses' performance. Each day brings new challenges in client care and the struggle to understand the human responses to actual and potential health problems. To meet these challenges competently, the nurse must have up-to-date assessment skills and a working knowledge of pathophysiological concepts concerning the common diseases and conditions presented. We believe that this book is a tool, providing a means of attaining that competency.

In the past, plans of care were viewed principally as learning tools for students and seemed to have little relevance after graduation. However, the need for a written format to communicate and document client care has been

recognized in all care settings. In addition, healthcare policy, governmental regulations, and third-party payor requirements have created the need to validate many things, including appropriateness of care provided, staffing patterns, and monetary charges. Thus, although the student's "case studies" are too cumbersome to be practical in the clinical setting, it has long been recognized that the client plan of care meets certain needs and therefore its appropriate use was validated.

The practicing nurse, as well as the nursing student, can welcome this text as a ready reference in clinical practice. It is designed for use in the acute care, community, and home-care settings. It is organized by systems for easy reference.

Chapter 1 examines current issues and trends and their implications for the nursing profession. An overview of cultural, community, sociological, and ethical concepts affecting the nurse is included. The importance of the nurse's role in collaboration and coordination with other healthcare professionals is integrated throughout the plans of care.

Chapter 2 reviews the historical use of the nursing process in formulating plans of care and the nurse's role in the delivery of that care. Nursing diagnoses, outcomes, and interventions are discussed to assist the nurse in understanding her or his role in the nursing process. In this book, we have also linked NANDA-I diagnoses with Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC) languages.

Chapter 3 discusses care plan construction and describes the use and adaptation of the guides presented in this book. A nursing-based assessment tool is provided to assist the nurse in identifying appropriate nursing diagnoses. A sample client situation with individual database and a corresponding plan of care is included to demonstrate how critical thinking is used to adapt nursing process theory to practice. Finally, a dynamic and creative approach for developing and documenting the planning of care is also included. Mind Mapping is a new technique or learning tool provided to assist you in achieving a holistic view of your client, enhance your critical thinking skills, and facilitate the creative process of planning client care.

Chapters 4 through 15 present plans of care that include information from multiple disciplines to assist the nurse in providing holistic care. Each plan includes a Client Assessment Database presented in a nursing format, and associated Diagnostic Studies. After the database is collected, Nursing Priorities are sifted from the information to help focus and structure the care. Discharge Goals are created to identify what should be generally accomplished by the time of discharge from the care setting.

Nursing diagnosis labels are then chosen and combined with possible related factors disignated by "may be related to," and the signs and symptoms or defining characteristics as "possibly evidenced by" if present to create Client Diagnostic Statements that provide a clear picture of the client's needs. Next, Desired Client Outcomes are stated in measurable behavioral terms to evaluate both the client's progress and the effectiveness of care provided.

Corresponding actions/interventions are designed to promote resolution of the identified client needs. The nurse acting independently or collaboratively within the health team then uses a decision-making model to organize and prioritize nursing interventions. No attempt is made in this book to indicate whether independent or collaborative actions come first because this must be dictated by the individual situation. We do, however, believe that every collaborative action has a component that the nurse must identify and for which nursing has responsibility and accountability.

Rationales for the nursing actions, which are not required in the customary plan of care, are included to assist the nurse in deciding whether the interventions are appropriate for an individual client. Additional information is provided to further assist the nurse in identifying and planning for rehabilitation as the client progresses toward discharge and across all care settings. A bibliography is provided as a reference and to allow further research as desired.

This book is designed for students who will find the plans of care helpful as they learn and develop skills in applying the nursing process and using nursing diagnoses. It will complement their classroom work and support the critical thinking process. The book also provides a ready reference for the practicing nurse as a catalyst for thought in planning, evaluating, and documenting care.

As a final note, this book is not intended to be a procedure manual, and efforts have been made to avoid detailed descriptions of techniques or protocols that might be viewed as individual or regional in nature. Instead, the reader is referred to a procedure manual or text covering Standards of Care if detailed direction is desired.

As we always say when we sign a book, "Use and enjoy."

MD, MM, and AM

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