Nursing care plans

Business

NURSING CARE PLANS Impaired Physical Mobility Assessment| Nursing Diagnosis| Scientific explanation| Objectives| Nursing Interventions| Rationale| Expected Outcome| S > ? O > Patient manifest:- weak and pale appearance – difficulty in standing and sitting – slowed movement – limited range of motion | Impaired Physical Mobilityr/t neuromuscular impairment aeb slowed movement | Limitation in independent, purposeful physical movement of the body or of one more extremities. Due to the patient's general status because of his brain damage secondary to CVA, patient develops weakness due to affectation in his cerebral artery.

This can result in decrease perfusion and the development of infarct. The reflex or muscular strength of a particular limb affected becomes weak, because of its altered control and function. Due to the brain affectation, with this prolonged status on the muscle limb it further weakens the body that may result to activity intolerance and there insufficient physiological or psychological energy to endure or complete required or desired daily activities.

| After 2 hours of Nursing Intervention, the patient will demonstrate technique or behaviors that enable resumption of activities. Instruct to change positions at least every 2 hours and placed on affected side. Position in prone position once or twice a day if patient can tolerate. monitor affected side for color edema, or other signs of compromised circulation. Support affected body parts using pillowsSchedule activities with adequate rest periods during the dayEncourage participation in self-care, occupational activitiesIdentify energy-conserving techniques for ADLs. | Reduces risk of tissue ischemia/injury.

Helps maintain functional hip extension but may cause increase anxiety, especially about ability to breath.

Edematous tissue is more easily traumatized and heals more slowly. To maintain position of function and reduce risk of pressure ulcers To reduce fatigue. Enhances self-concept and sense of independence. Limits fatigue, maximizing participation| The patient demonstrated techniques that enable resumption of activities.

| Risk for impaired skin integrity Assessment| Nursing Diagnosis| Scientific explanation| Objectives| Nursing Interventions| Rationale| Evaluation| S; OO; Patient manifested:; right sided paralysis; limited /difficulty of movements| Risk for impaired skin integrity r/t decreased bed mobility a. . b limited/difficulty of movements. | Pressure ulcers develop when soft tissue (skin, SQ tissue and muscle) are compressed between a bony prominence and a firm surface for a prolonged period of time. | After 1-hour of Nursing intervention, the client and SO will verbalize and demonstrate understanding on the proper bed positioning that can help reduce risk of developing pressure ulcers.

-monitor V/S-provide bedside care-support affected body parts using pillows -encourage adequate fluid intake-change clients bed position every two(2) hours| -gather baseline data for further comparison-to give comfort to the patient-to maintain position of function and reduce risk of pressure ulcers. -to avoid dehydration and skin dryness. -to generate blood flow and reduce the risk of pressure ulcers. | After 1-hour of Nursing intervention, the client and SO have verbalized and demonstrated understanding on the proper bed

positioning that can help reduce risk of developing pressure ulcers. Risk for unilateral neglect Assessment| Nursing Diagnosis| Scientific Explanation| Objectives| Nursing Interventions| Rationale| Expected Outcomes| S- OO- muscle strength test of right arm: 3/5; right leg: 2/5; left arm: 4/5; left leg: 4/5-needs assistance in performing ADLs| Risk for unilateral neglect r/t muscle weaknesssecondary to CVA| A cerebrovascular accident (CVA) is a sudden loss of function resulting from disruption of the blood supply to a part of the brain.

A stroke is an upper motor neuron lesion and results in loss of voluntary control over motor movements.

Because the upper motor neurons decussate (cross), a disturbance of voluntary motor control on one side of the body may reflect damage to the upper motor neurons on the opposite side of the brain. | Short Term: After 15-20 mins of NI, the pt will participate in the performance of range of motion exercises on the extremities. Long Term: After 2 days of NI, the pt will increase the utilization of the affected extremities with due assistance from the SO as evidenced by an increase in the muscle strength test. | ; Monitor and ssessed vital signs; reassess patient’s general physical condition> Perform PM Care> Frequently monitor vital signs > Perform muscle strength test regularly> Instruct patient and significant others on a passive range of motion on the right extremities> Promot adequate rest> Assist patientwith self-care activities> Maintain body alignment in functional position> Shift patient’s attention towards the affected side; Administer due meds| To obtain baseline data; To note for any abnormality; To enhance well-being ; provide comfort; To note significant changes in vital signs; To

determine muscle functioning on the extremities; To increase strength and mobility; To promote comfort and relaxation; To prevent Injury and fatigue; To promote and stimulate circulation; To stimulate and increase patient's awareness on the affected side> To treat underlying medical condition| Short Term: The pt shall have participated in the performance of range of motion exercises on the extremities.

Long Term: The pt shall have increased the utilization of the affected extremities with due assistance from the SO. | Impaired verbal communication Assessment| Nursing Diagnosis| Scientific explanation| Objectives| Nursing Interventions| Rationale| Expected Outcome| S> ?

O> The patient manifested: * Slurring of speech * Glasgow Coma Scale: verbal response score of 4 out of 5 * Absence of eye contact * Difficulty in use of facial expression| Impaired verbal communication related to neuromuscular impairment| Infarction in the brain may lead to impairment in hearing and speech thus predisposing the patient to verbal impairment. For this case, the frontal area which is responsible for the personality, behavior, motor function, Broca's area (expressive speech center), concentration, and abstract thought was affected. This led to aphasia which was the partial or complete inability to use or comprehend language resulting to impaired verbal communication. | Short term: After 2 hours of nursing interventions, the patient will be able to indicate an understanding of the communication problem and the importance of establishing a method of communication. Long term: After 2 das of nursing nterventions, the patient will be able to demonstrate congruent verbal and nonverbal communication with the help

of his family| INDEPENDENT: * Assess type/degree of dysfunction * Listen for errors in conversation and provide feed back.

* Ask patient to follow simple commands (e. g. “ Close your eyes, point to the door”); and repeat simple words or sentences. * Have the patient produce simple sounds like “ ah”, “ sh”, cat * Provide alternative methods of communication: e. g.

writing on a piece of paper, magic slate, using pictures. * Anticipate and provide patient’s needs * Talk directly to the patient, speaking slowly and distinctly. Use yes/no questions to begin with, progressing in complexity as the patient responds. * Speak with normal volume and avoid talking too fast. Give the patient ample time to respond. Talk with pressing for a response.

Encourage SO to persist in efforts to communicate with the patient like reading mail, discussing family happenings even if he is unable to respond appropriately * Discuss familiar topics such as job, family, hobbies. COLLABORATIVE: * Consult with/refer to speech therapist| * Helps determine area and degree of brain involvement and difficulty the patient has with any or all steps of the communication process. The patient has difficulty forming words but can understand spoken words. * Patient may lose ability to monitor verbal output and be unaware that communication is not sensible. Feedback helps the patient realize why the health care provider is not responding appropriately and provides opportunity to clarify content/meaning. Tests for receptive aphasia * Identifies dysarthria because motor components of speech (tongue, lip movement, breath control) can affect articulation and may/may not be accompanied by expressive aphasia *

Provides for communication needs and desires based on underlying deficit * Helpful in decreasing frustration when dependent on others and unable to communicate desires.

* Reduces confusion or anxiety at having to process and respond to large amount of information at one time. As retraining progresses, advancing complexity of communication stimulates memory and further enhances word/idea association * The patient is not necessarily hearing impaired and raising voice may irritate him. Forcing responses can result to frustration and may cause him to resort to " automatic speech" like garbled speech, obscenities. * It is important for family members to continue talking to the patient to reduce isolation, promote establishment of effective communication, and maintain sense of connectedness with family. Promotes meaningful conversation and provides opportunities to practice skill * Assesses individual verbal capabilities and sensory, motor and cognitive functioning to identify deficits and therapy needs| Short term: The patient and his SO were able to understand the importance of establishing an alternative method of communication and stated " Ah, pwedi ming gawan yan.

" Long term: The patient was able to demonstrate congruent verbal and nonverbal communication to SO and health care provider. | NURSING CARE PLAN ASSESSMENT| NURSING DIAGNOSIS| INFERENCE| PLANNING| INTERVENTION| RATIONALE| EVALUATION| Subjective:" Hindi siya makatagilid sumasakit daw ung bali niya sa may bewang kapag gumagalaw" as verbalized by the sn of the patient.

Objective: * Impaired ability to turn side to side * Impaired ability to move from supine to sitting vise versa. * (+) presence of pelvic fracture * (+) General weakness * Tremors noted on left arm and hands| > Impaired bed mobility related to pain secondary to musculoskeletal impairment. | Trauma(slipping)bone fracture at pelvic boneDisruptions of periosteum and blood vesselsDestruction if tissueBleeding occursPainImpaired bed mobility| After the rotation and nursing intervention the significant other of the patient will: a.

Verbalize understanding of the situation /risk factors, individual therapeutic regimen and safety measures. b. Demonstrate techniques/ behaviors that will enable safe repositioning c.

Maintain position of function and skin integrity of the patient as evidenced by absence of contractures, foot drop, decubitus, etc. | * determine diagnoses that contribute to immobility (e. g.

fractures, hemi/para/tetra/quadripegia) * Note individual risk factors and current situation, such pain, age, general weakness, debilitation * Determine perceptual/ cognitive impairment to follow directions * Determine functional level classification * Note presence of complications related to immobility * Observe skin for reddened areas/shearing. Provide appropriate pressure to relief * Provide regular skin care if appropriate * Assist with activities of hygiene, toileting, eeding, as indicated. * Involve client S/O in determining activity schedule| * To identify causative/ contributing factors. * To assess patients functional ability * To reduce friction, maintain safe skin/tissue pressures and wick away moisture * To prevent complications * To promote optimal level of functioning * To promote commitment to plan, maximizing

outcomes. | After the rotation and nursing intervention the significant other of the patient will: a. Verbalize understanding of the situation /risk factors, individual therapeutic regimen and safety measures.

b. Demonstrate techniques/ behaviors that will enable safe repositioning c.

Maintain position of function and skin integrity of the patient as evidenced by absence of contractures, foot drop, decubitus, etc. | ASSESSMENT| NURSING DIAGNOSIS| INFERENCE| PLANNING| INTERVENTION| RATIONALE| EVALUATION| Subjective:” Hindi na makagalaw si nanay simula nung na-stroke siya ” as verbalize by the son of the patientObective: * (+) General body weakness * Tremors noted on left arm and hands * Inability to perform gross/fine motor skills * (+) Paralysis of left side of the body * functional level scale: 4 (does not participate in activity)| > Impaired physical mobility related to Neuromuscular impairment| Hypertension? Occlusion within vessels of the brain parenchyma?

Disruption of blood supply in the brain area? Tissue and cell necrosis? Destruction of Neuromuscular junctions? Interruption in transportation of electrical impulses to the neuromuscular receptors? MYALGIA/QUADRI OR HEMIPLEGIA| After the rotation and nursing intervention the patient will: a. Maintain position and function and skin integrity as evidenced by absence of contractures, foot drop, decubitus and so forth. b.

S/O will demonstrate techniques/ behaviors that will enable safe repositioning| * Determine diagnosis that contributes to immobility (e. g. fractures, hemi/ para/ tetra/ quadriplegia) * Assess nutritional status and S/O others report of energy level. Determine degree of immobility in relation to

functional level scale * Assist or have significant other reposition client on a regular schedule (turn to side every 2 hours) as ordered by the physician * Provides safety measures (side rails up, using pillows to support body part) * Encourage patient’s S/O’s involvement in decision making as much as possible * Involve S/O in care, assisting them to learns ways of managing problems of immobility. | * To identify causative/ contributing factors. * To assess functional ability * To prevent complication * To provide safety * Enhances commitment to plan optimizing outcome * To impart health teaching.

| After the rotation and nursing intervention the patient will: c. Maintain position and function and skin integrity as evidenced by absence of contractures, foot drop, decubitus and so forth. d. S/O will demonstrate techniques/ behaviors that will enable safe repositioning|

ASSESSMENT| NURSING DIAGNOSIS| INFERENCE| PLANNING| INTERVENTION| RATIONALE| EVALUATION| Subjective:” Simula nung na i-stroke si nanay, na bedridden na siyaObjective:(+) NGT insertionPatient is unable to: [HYGIENE] * Access and prepare bath supplies * Wash body * Control washing mediums[DRESSING AND GROOMING] * Obtain articles for clothing * Put on clothes * Maintain appearance at an acceptable level[FEEDING] * Prepare/obtain food for ingestion * Handle utensils * Bring food to mouth * Chew and swallow up food * Pick up food[TOILETING]Go to the toilet| Self care deficit : hygiene, dressing and grooming, feeding and toileting related to Neuromuscular impairment| Hypertension? Occlusion within vessels of the brain parenchyma? Disruption of blood supply in the brain area?

Tissue and cell necrosis? Destruction of Neuromuscular junctions? Interruption in transportation of electrical impulses to the neuromuscular receptors? MYALGIA/QUADRI OR HEMIPLEGIA| After the rotation and nursing interventions. The patient should: a.

meet all therapeutic self care demands in a complete absence of self care agency b. ABSENCE OF S&S OF NUTRITIONAL DEFICIT. [Adequate nutritional intake] c. GOOD SKIN TURGOR, NORMAL URINE OUTPUT, ABSENCE OF EDEMA, HYPER AND HYPOVOLEMIA [Fluid and Electrolyte balance] d. ABSENCE OF DECUBITUS ULCERS AND FOUL ODORS IN BETWEEN LINENS/CLOTHING AND SKIN [Clean, Intact skin and mucus membrane] e.

ABSENCE OF ABDOMINAL AND BLADDER DISTENTION, RECTAL FULLNESS AND PRESSURE, PAIN IN DEFECATION [Meeting toileting demands]| * Provide enteric nutrition VIA NG Tube feeding. High fowlers for at least 15 minutes after feeding. * Careful I/O Monitoring and apply necessary dietary restrictions. * Change position at least ONCE every two hours or more often when needed. * Provide padding for the elbows, needs, ankles and other areas for possible skin abrasion.

* An adult diaper should be WORN at all times. Change the diaper as soon as patient defecated. * Promote an Environment conducive to rest and recovery. Decrease stimuli and Metabolic demand of the body. * Passive ROM Exercises Early morning once a day, 10 times targeting both upper and lower extremities.

gt; Lastly, Do health teaching when S/O is at the optimum level to receive information. | * To meet patient’s need for an adequate nutritional intake. *

To establish careful assessment on patients fluid and electrolyte balance. * To prevent decubitus ulcerations. * To protect the patient’s skin integrity maintaining his first line of defense against sickness and infection.

* To prevent soiling of bed sheets, clothes and linens providing maximum comfort and prevention of skin irritation if feces remain in contact with the patient’s skin for a long time. * To conserve energy promoting rest and recovery. * This is to improve circulation, reducing the risk of atheromatous formation. 10.

To educate the S/O what factors have contributed to the client’s illness and educating them to decrease, if not totally eliminate those contributory factors to prevent recurrence of the disease and promote change for a healthy lifestyle. | After the rotation and nursing interventions.

The patient should: f. meet all therapeutic self care demands in a complete absence of self care agency g. ABSENCE OF S&S OF NUTRITIONAL DEFICIT. [Adequate nutritional intake] h. GOOD SKIN TURGOR, NORMAL URINE OUTPUT, ABSENCE OF EDEMA, HYPER AND HYPOVOLEMIA [Fluid and Electrolyte balance] i. ABSENCE OF DECUBITUS ULCERS AND FOUL ODORS IN BETWEEN LINENS/CLOTHING AND SKIN [Clean, Intact skin and mucus membrane] j.

ABSENCE OF ABDOMINAL AND BLADDER DISTENTION, RECTAL FULLNESS AND PRESSURE, PAIN IN DEFECATION [Meeting toileting demands]|