BEAUTIFULNURSING CAREPLAN

Before you begin your care, it is important to remember ADPIE.

A: Assessment

Assessment is collecting subjective and objective data from the patient and secondary sources. ex: Vitals

D: Diagnosis

Diagnosis is identifying the patient's problems and priority of care.

There are three types of diagnosis: RISK, ACTUAL and HEALTH PROMOTION nursing diagnosis.

Risk: the patient is at risk for developing _____ because of health conditions/life processes/etc.

Actual: The patient has ____ because of health conditions/life processes/etc. It is not a risk because they have it.

Health Promotion: a clinical judgement of motivation, desire to enhance wellbeing of patient.

P: Planning

Planning is setting goals of care and desired outcomes that will be appropriate to prevent, manage, or enhance the patient's condition.

I: Implementation

Implementation is performing the nursing actions identified in the planning. These should directly correlate to the goals.

E: Evaluation

Determine if the goals were met or not. If not, the patient may need to be reassessed and a new priority plan or care should be established.

HOW TO START

Forming a Nursing Diagnosis:

1. The problem/nursing diagnosis from NANDA.
2. Etiology of related to "r/t"
3. Symptoms "AEB"

Example: Acute Pain r/t tissue trauma AEB pain level of 9 on 1-10 scale and winces in pain.

Forming a Nursing Goal:

They should be **SMART** and correlate with the nursing diagnosis.

S: Specific
M: Measurable
A: Attainable
R: Realistic
T: Time framed.

Example relating to nursing diagnosis above.

Ex: Patient will verbalize a decrease in pain by rating less than 5 on 1-10 pain scale within 24 hours of receiving pain medication.

Forming a Nursing Intervention:

Nursing interventions are treatments or actions that will benefit the patient to meet the goal as stated previously. Interventions can either be nurse initiated (done by nurse) or collaborative (done as a team effort with other health care professionals).
These interventions should be EB (evidence-based) and there are many great examples in the NANDA book.

Examples: Nurse will assess the patient's pain level Q2 hrs. while patient is awake, nurse will administer ____ per md instructions to decrease pain levels, nurse will educate patient on how to prevent or manage pain with 4 nonpharmacological techniques, nurse will reposition patient Q2 hours to increase comfort of patient.

NURSING DIAGNOSIS #1

PRIORITY

Diagnostic Statement:	**Intervention:** What treatment or actions are you going to use?	**Implementation:** What actions did you perform to carry out the plan of care?
R/T:	**Intervention #1**	**Implementation #1**
AEB (symptoms, not used if risk diagnosis):	**Intervention #2**	**Implementation #2**
Justification for Prioritization (Use Safety, ABC's, Maslow's)	**Intervention #3**	**Implementation #3**
Outcome- Make it SMART!		**Evaluation (Did it work or not? Why not?)**