Understanding Care Plans Flowsheet

Purpose is to help you learn how to identify problems your patients might face & how to address them

Answer these questions before you start:

step 1: assess	
#1 - What	The disease or condition you're making the care plan for - it can be either specific to a patient or a common occurence on your unit
#2 - Complications	Thinking about your patient/condition, what can go wrong in their care? Has something already gone wrong? - This will help you choose your NANDA diagnosis Example: Immobile patients (#1) → pressure ulcers (#2)

Starting your care plan:

step 2: diagnose	
#3 - NANDA list	Keep in mind this is NOT a medical diagnosis - there is an approved list that you are limited to available here: http://www.nandanursingdiagnosislist.org/
#4 - Diagnosis	Choose your NANDA approved nursing diagnosis The list is long & can be intimidating. To find the right diagnosis ask these questions: 1. Is this diagnosis applicable to your answer in #1? 2. Would your answer in #2 be a sign or symptom of the diagnosis? Sometimes the answer in #2 can also be a NANDA diagnosis - Example: My patient has C.Diff (#1) → causes horrible diarrhea (#2) → diarrhea is both a complication **&** an approved NANDA diagnosis Continuing example from #2: Immobile patient (#1) → pressure ulcers (#2) → impaired skin integrity (#4)
#5 - Related to	Your answer for #1 - This is why its important to make sure your nursing diagnosis is applicable to your answer in #1 Continuing example: impaired skin integrity (#4) → *related to* Immobile patient (#1)
#6 - Evidenced by	Your answer for #2 - This is why its important to see if your answer in #2 could be a sign or symptom of the diagnosis Continuing example: impaired skin integrity (#4) → *related to* Immobile patient (#1) → *as evidenced by* pressure ulcers (#2)
#7 - Patient statement	If you're doing a nursing diagnosis for a specific patient - include something they said that goes along with your answer in #2 Continuing example: impaired skin integrity (#4) → *related to* Immobile patient (#1) → *as evidenced by* pressure ulcers (#2) → *and* "the back of my left hip is really hurting" (#7).

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step 3: setting goals	
#8 - Outcome	Thinking about your sparkly new nursing diagnosis that you made in Step 2, what would the resolution to the problem be? Continuing example: Nursing Dx from step 2 → patient will regain integrity of skin surface & report alterations in sensation or pain
#9 - Making them SMART	Purpose of this is to help you bridge into the next step & set both you & the patient up for success. Its *very* important, especially for Step 6. Once you have your answer for #8 you have to make it S.M.A.R.T: - *Specific*: generalized statements aren't going to help you much, tailor them to the patient & the problem - *Measurable*: make sure theres an end in sight, you need to know when you've accomplished this goal. - *Achievable*: shoot for the moon, land among the stars, right? Not here! This goal has to be something that's doable, don't set yourself & your patients up for disappointment. - *Relevant*: no need to multitask, keep this goal in the pocket. - *Timed*: whether its before discharge, in a matter of hours/days/weeks, just put a time stamp on it. Continuing example: Nursing Dx from step 2 → patient will regain integrity of skin surface on left posterior hip & will consistently report alterations in sensation or pain over any other bony prominences before discharge.

step 4: plan your interventions	
#10 - Now what?	You know what your problem is, you know what your end goal looks like, now how are you going to get there? Most care plans require 3 interventions & unless otherwise stated - that's my golden number. Usually when I choose my interventions I like to follow this general guideline: - *Intervention 1*: What can I, the nurse, physically do more of to resolve the problem? - *Intervention 2*: What can the patient do to resolve the problem? This includes patient education & teaching - *Intervention 3*: What needs to happen to prevent this from happening again or getting worse? *Remember: all of your interventions should be done to help reach the goal you made in Step 3. Continuing example: Nursing Dx from step 2 → SMART Goal from Step 3 → Strict compliance to repositioning patient q2h (#10-1). Educate patient on risks/complications of pressure ulcers & importance of notifying healthcare team as soon as pain or loss of sensation occurs (#10-2). Daily monitoring of the site for changes & cleaning in accordance to MD orders (#10-3).

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step 5: back up what you say with rationales	
#11 - But why?	The importance of knowing ***why*** you do something can't be overstated. Purpose being that thorough understanding of the 'whys' is the foundation of developing your critical thinking skills. So when you get annoyed with your instructor asking 'well, why?' more times than a toddler, try to remember that its going to serve you in the long run. Reflect on your 3 interventions from Step 4 & ask yourself: - Why is this going to help get to my goal?
#12 - Evidence Based Nursing	Theres a ton of aids out there to help you back up your rationales. Browse the index of your textbooks for your answer in #2 → Look for treatments & nursing interventions → something is inline with the interventions you laid out in Step 4 - use it. Other, non-textbook, resources to help guide your search for 'whys': - https://scholar.google.ca/ - https://www.healthevidence.org/search.aspx - Your schools library (online & in-person resources) General guidelines for references & citations: - Minimum 3 total references that are within the last 5 years - Use the intext citation after stating your rationale. - Give your references their own page & keep them alphabetical - Double-spaced size 12 Times New Roman/Arial - Hanging indent

step 6: evaluate	
#13 - Now what?	When you reach the time-limit that you set for this goal or you think you achieved it, how will you know? This section wraps everything up nicely. Step 6 is why a solid SMART goal in Step 3 is so important. If your goal from Step 3 meets the criteria to be a SMART goal, it will make evaluating progress pretty easy. Try not to just restate your goal (#9), you already did the work to make sure your interventions (#10) were inline with it. All you have to do is explain the impact of your interventions (#10-1/2/3) & what they would have to achieve for your goal (#9) to be a success. Continuing example: Nursing Dx from step 2 → SMART Goal from Step 3 → Interventions from Step 4 → Rationales for each intervention from Step 5 → Patient's ulcer has resolved/lessened in severity (#13-1). Patient's call-bell is always in reach & verbalizes discomfort quickly (#13-2). Site has remained free of infection & no new sites have appeared (#13-2)

CONGRATULATIONS! You made a care plan!
use the SVNC template for easy & clean formatting

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