NSG 3017: WOMEN'S HEALTH
NURSING CARE PLAN

ASSESSMENT FROM DAY 1	PLAN RO DAY 2	IMPLEMENTATION/EVALUATION OF DAY 2
DATA (In a time sequence) **SUBJECTIVE**: What the patient (or significant other if patient unable to speak) says. **OBJECTIVE**: Include only data which supports the problem; do not repeat Day 1's data in Day 2's assessments. A. **Physical Assessment** --signs and symptoms --treatments --lab data with dates --diagnostic studies --drug therapy, etc. --information from the chart B. **Psychosocial Assessment**: --adaptation/coping mechanisms --roles --thought processes --shared values --communication --educational background, etc. --economic status C. **Spiritual Assessment** --beliefs --religious practices --self-actualization, etc. MUST HAVE SUFFICIENT DATA TO SUPPORT YOUR NURSING DIAGNOSIS! MUST HAVE DAILY CHANGES INDICATED AFTER INITIAL ASSESSMENT AND BASED ON PREVIOUS DAY'S INTERVENTIONS (Day 2). **PROBLEM STATEMENT (NURSING DIAGNOSIS)** USE NURSING DIAGNOSIS FORMAT AS ACCEPTED BY NAANDA. NEED: INDICATE AND IDENTIFY MASLOW OR KALISH.	GOAL STATEMENT (EXPECTED OUTCOME) MUST BE: --Patient and/or family oriented --Positively stated --Realistic --Measurable within 8 hr. time frame --Demonstrate patient progression when appropriate PLANNED INTERVENTIONS **BE SPECIFIC! INDIVIDUALIZE: FOR YOUR PATIENT:** List and number consecutively in the order in which you intend to carry out the plan. Indicate specific time sequences (such as "at 0800, 1000 and 1200" not "q 2 hr"). Daily changes must be indicated. State scientific rationale for each planned intervention and be prepared to tell instructor the source of that rationale (text, journal, lecture, etc.)	GOAL EVALUATION (ACTUAL OUTCOME) State if goal met or not met. Validate by indicating S and O data to support achievement or not of expected goal. SUMMARY STATEMENT OF INTERVENTIONS Document specific planned interventions by number. Indicate if Implemented. ("#1-3 implemented") If not implemented, or only partially implemented, indicate reason. ("#4 not implemented. Epidural catheter removed late last night.") ASSESSMENTS MADE AS RESULT OF IMPLEMENTED PLANS MUST BE DOCUMENTED IN NEXT DAY'S ASSESSMENT DATA, **except for DAY 3 assessments as plan of care is implemented.** LAST COLUMN OF SECOND PAGE OF CARE PLAN MUST INCLUDE A BRIEF SUMMARY OF ASSESSMENTS OF PATIENT RESPONSES TO DAY 3's INTERVENTIONS! REVISION OF PLAN Provide brief rationale for alternative approaches to planned care and/or changes in priority in this problem or plan. List by number any revisions, omissions, or additions. Reflect these changes in the next day's planned interventions.

ASSESSMENT FROM SECOND DAY	PLAN - FOR THIRD DAY	IMPLEMENTATION/EVALUATION OF THIRD DAY
DATA: (In time sequence) **Only NEW data gathered while providing care on second day of care goes here.** subjective: (Symptoms) What the patient (or significant other if patient unable to speak) said while care being given on **Second day** of care **only.** (Covert cues) 1100 "Oh, it's about an 8 on that scale. It got worse after the epidural was pulled and then the baby nursed" 1300 "I feel so much better. I've even walked in the hall and it's, maybe, a 4 or 5 right now." objective: (Signs) Documented in telegraphic style, what you observe, read, hear from health team members (Overt cues) Ex. Chart: 0700 epidural catheter intact upon removal. minimal redness, no drainage from insertion site MAR 0730 Oxycodone 5 mg/Acetaminophen 325mg 2tabs 0945 Rubbing abdomen, squinting eyes and frown on face. Baby at breast, audible swallowing heard. 1055 Grimaces when getting out of bed to walk to bathroom. Walks bent forward slightly. Will reflect continuance of problem. If data gathered on Day 2 of care reflects the problem no longer exists, include that data under Summary Statement of Interventions and under Revision of Plan on first page of care plan – i.e. Based on above data, problem resolved. (A second page is then not needed.) PROBLEM STATEMENT: **(NURSING DIAGNOSIS)** May need to rewrite the statement from Day 1 or may need to revise the "R/T", but the **Label** (*Ex. "Acute Pain"*) must stay the same. **NEED:** Identify need category of problem from **Maslow's** Heirarchy *(Ex. Physiological need for comfort)*	GOAL STATEMENT (EXPECTED OUTCOME) MUST BE - – patient and/or family oriented. i.e. - "The patient will report pain ..." – positively stated – measurable within a 6-8 hour time frame which is identified – realistic and achievable by the patient or family – demonstrate patient progression when appropriate *Ex. The patient will report pain as a 4 or less on a scale of 1-10 by 1500 on (date).* **PLANNED INTERVENTIONS: (NURSING ORDERS)** Can indicate – "Continue #1-#6 of Day 1 Plan" rather than rewrite them. HOWEVER - be sure to assess if each intervention needs to be done as worded - i.e. - do you need to teach something again? Or just "review teaching of Day 1" List and number consecutively **in the order in which you intend** to carry out the plan Indicate specific time sequences ("at 0800, 1000, & 1200 " rather than "q2h") Daily changes must be indicated State scientific rationale for any new interventions and the source of that rationale (specific text, journal, lecture, etc.)	**GOAL EVALUATION (ACTUAL OUTCOME)** State if goal met or not met. Validate by indicating S and O data to support achievement or not of expected goal. **SUMMARY STATEMENT OF INTERVENTIONS** Document specific planned interventions by number as either implemented, partially and not implemented. **Indicate SPECIFIC ASSESSMENTS which reflect patient responses to Day 3's interventions** (There is no "page 3" so those **assessments** need to be reflected here, reflecting how the patient responded to the **Day 3 interventions.)** Implemented #1."I really feel so much better", smiling, holding baby in her lap. Implemented #2. Pain level at 0630 – 5/4; One Toradol taken at 0630. Pain level at 0845 – 8/4; Two percocets taken. Pain level 1245 -- 5/2 One percocet and 1 Toradol taken together. **REVISION OF PLAN:** List by number, any revisions, omissions, or additions with a brief explanation for why these are necessary. If assessment indicates resolution of the **problem** - ***not just achievement of the goal*** - then state - . Based on above data, problem resolved.