Cape Girardeau Career & Technology Center
School of Practical Nursing
Patient Assessment & Care Plan Packet

DATE__________ **STUDENT'S NAME**____________________________ **CLINICAL ROTATION**____________ **INSTRUCTOR**___________________________

Your clinical instructor will look at all of your paperwork at the beginning of each clinical day. Verbal and written suggestions and corrections will be given to improve your paperwork. **DO NOT REWRITE ANY PORTION OF THE PAPERWORK UNLESS DIRECTED TO BY THE INSTRUCTOR**
On the last day of your clinical week, turn in all your clinical paperwork in a pocket folder to your clinical instructor. The clinical instructor will review your completed paperwork, assign a grade of either ACCEPTABLE OR UNACCEPTABLE and then return the graded paperwork to you.

DIRECTIONS: Complete this packet in blue or black ink ***prior to beginning care for each assigned patient.*** Follow these three steps to prepare for the clinical rotation.

STEPS TO FOLLOW:
Step #1 **Data-Gathering**

Gather information from the chart, the patient, the staff, etc. Fill out as much of the Pt Health Hx Sheets as possible while at the hospital
General Information
Social History
Health History BEFORE this Admission
Current Health Status (Assessment)
Admitting Diagnosis

Step #2 **Research**

Fill out the Research Sheets by looking up the following information:
Disease Information
Diagnostic Tests (the instructor will determine how many, how recent, etc.)
Medication Information
Unknown Words
Patient Teaching
NOW.....USING A HIGHLIGHTER..HIGHLIGHT ALL ABNORMALITIES, PROBLEMS, AND NEEDS

Step #3 **Care Plan**

Use the highlighted abnormalities, problems, and needs, choose 2 priority needs & write a Nursing Diagnosis for each of the priority needs, with "related to" and "as evidence by".
Write a Patient/Family Goal and a Nursing Goal for each nursing diagnosis.
Write 3 Interventions with Rationale for each nursing diagnosis.
Write an Evaluation for each of the interventions at the end of each clinical day.
Update and revise your interventions as needed (for example, patient condition changes, new orders written, etc.)

<table>
<tr><th></th><th>PATIENT HEALTH INFORMATION</th></tr>
<tr><td>S-SITUATION</td><td>PT INITIALS _______ RM #_________ AGE_________SEX_____CODE STATUS___________ ADMISSION DATE__________

ADMISSION C/O ______________________________
DX ____
ADMITTING PHYSICIAN____________________________
CONSULTING PHYSICIAN(S)_________________________________</td></tr>
<tr><td>B-BACKGROIUND</td><td>HT_________WT________ MARRITAL STATUS_________ RELIGIOUS AFFLIATION _______________
SMOKER Y/N -HOW MUCH _________ DATE QUIT___________ ALCOHOL CONSUMPTION Y/N- HOW MUCH ___________
PLACE/TYPE OF RESIDENCE (NOT ADDRESS) _______________

MOST RECENT VSs (INCLUDE TIME/DATE) ______________________________
MOST RECENT BLOOD SUGAR (INCLUDE TIME/DATE) _______________ TX ______________
24 HOURS INTAKE______________ OUTPUT_______________

SURGICAL HX: (INCLUDE TYPE OF SURGERY & YEAR)

HOME MEDICATIONS: (NAMES ONLY)

HEALTH HX: (INCLUDE DISEASES, DISORDERS, OR PROBLEMS-PLACE UNDER THE APPROPRIATE BODY SYSTEM)
CARDIO RESP GI URINARY

NEURO/SENSORY REPRODUCTIVE ENDOCRINE MUSCULOSKELETAL

MENTAL HEALTH INTEGUMENTARY</td></tr>
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DAILY NURSING ASSESSMENT **DATE:** ___________ **TIME:** ___________

NEURO	Orientation Mood Pain	Alert ___ Oriented: Person ___ Place___ Time ___ Situation/Event ______ Appropriate___ Restless ___ Lethargic ___ Unresponsive ___ Agitated ___ Pain rating (0-10) ___ Location & description ______________Pain intervention: ________________
SKIN	Integrity Temperature Color Wound/abrasions Surgical incision/site	Intact ___ (no tears, abrasions, wounds) Warm & dry ____ cool___ clammy ____ moist _____ diaphoretic ____ Pink/natural___ pale ___ cyanotic ____ flushed ___ jaundice_____ None __ location(s)______________ size_____________ drsg____________ None __ location (s)______________ appearance ____________ drsg__________
CARDIO	Edema Pulses Capillary refill Rhythm/rate/sound Telemetry	None ___ Location: __________________________ Amount: 1+ 2+ 3+ 4+ pedal pulses: strong/absent/faint_________radial pulses: strong/absent/faint _______ WDL (<3 secs) ___ delayed (>3 secs) ______ Apical findings: Rate ______Regular _______ irregular _____ murmur _________ Yes_____no_______ telemetry reading _________
RESP	Respirations Breath sounds Cough/sputum Oxygen/Oximetry	Even/unlabored ______ rate ______labored _____ shallow ____ SOB __________ CTA x _____ lobes Abnormal lung sounds- crackles ___________ wheezing __________ diminished _______________ None ____ Cough _____ productive_____ nonproductive ____ describe sputum ______________________ Room air ___ oxygen: nasal cannula ______ mask ______ O2/L _______ PO _____%
GI	Diet/appetite Abdomen Bowel sounds LBM Tubes:	Diet: __________________ appetite _______________ Soft ____ firm ___ flat _____ distended______ gravid ____guarded_____ Present____ # of quadrants ______ flatus ______ Date: __________ appearance/consistency of last stool: ____________________ NG: _____ Nare:______ suction: high-low-clamped TF: type_____________ freq________ residual checks
GU	Urine	Voiding_____ incontinent_____ catheter_________ cath type ___________ Dysuria: yes-no
MUSCULO-SKELETAL	Tone/Strength grips	MAE _______ weakness ____________________ Strong _________ R _____________ L_______________
ACTIVITY	Activity _______________ Hygiene	Bedrest_____ BR w/ BRP ______ up ad lib_____ up with assist x _______ BSC_____ Turn q _______ HOB @ _____ degrees up to chair _____ ambulate x ______ ____ Independent_____ assist______ Shower______ partial bath____ set-up ______ complete_______ oral care _______
SAFETY	Fall risks __________ Patient safety needs	Bed low______ call light w/in reach_____ siderails up x _____ room free of clutter____ Gait belt in use ____ nonskid socks ______ ____ Bracelets: ID, allergy, fall risk, code status ________________
LINES & DRAINS	Intravenous _______________ Drains	None ___ peripheral____ midline _____ central line ____ #1 location________ size _____ site appearance ______ fluids _________________________ rate _________ #2 location _______ size ____ site appearance ______ fluids __________________________rate ________ ____ Wound vac: ______ location: ________ Hemovac: ___location: ___________drainage description: ________________
ISO	Precautions	Standard___ contact___ respiratory___ droplet___ neutropenic____ Reason for isolation:

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DISEASE/DISORDER INFORMATION

Using your NOA textbook or other reliable resource, complete the information below regarding your assigned patients admitting disease/disorder.

Identify what resource you used for the information below.

Resource: ______________________________

DEFINITION OF THE DISEASE/DISORDER	SIGNS/SYMPTOMS
CONTRIBUTING FACTORS/CAUSES/PATHOPHYSIOLOGY	COMMON MEDICATIONS PRESCRIBED
USUAL TREATMENT/MANAGEMENT (medical & nursing)	POSSIBLE NURSING DIAGNOSIS (LIST AT LEAST 3)

DIAGNOSTIC TESTS

Find the most up-to-date diagnostic tests that relates to your patient's condition. This can include blood work, x-ray, scans, cultures, biopsies, EKGs, endoscopic procedures, etc.

DIAGNOSTIC TEST	NORMAL VALUE	PATIENT'S RESULTS	WHY WAS THE TEST PREFORMED?	HOW DID THIS RESULT CHANGE THE COURSE OF TREATMENT?

MEDICATION INFORMATION

Obtain information about the medications ordered during your **scheduled** clinical time. Day 0800-1400 or Evening 1600-1000

MEDICATION NAME	SCHEDULED TIME	DOSE	ROUTE	WHY IS THE PATIENT TAKING THIS MEDICATION

CARE PLAN

Create a care plan by determining the top 2 nursing priorities/problems that relate to this hospitalization. Think about Maslow's Hierarchy of Need's and the ABCs when determining the priority needs.

Include the related to (r/t), AEB, interventions, & rationale. The interventions and care plan should be evaluated daily and adjusted as needed.

ADMITTING DX: ____

Nursing diagnosis #1		
Nursing Interventions:	**Rationale:**	**Evaluation:**
1.		
2.		
3.		
NURSING GOAL:		
PATIENT/FAMILY GOAL:		

ADMITTING DX:

Nursing diagnosis #2		
Nursing Interventions:	**Rationale:**	**Evaluation:**
1.		
2.		
3.		
NURSING GOAL:		
PATIENT/FAMILY GOAL:		

UNKNOWN WORDS: Identify 4 unknown words and write the definitions below

Unknown words	Definitions

TEACHING: what teaching does the patient/family need prior to discharge that relates to their condition and/or treatment plan?

DIET	WOUND/INCISION CARE
ACTIVITY	MEDICATION
TUBES/DRAINS	OTHER