

Time	Patient Specific Nursing Needs	Measurable Goal	Nursing Interventions	M	E	N	Evaluation / Outcome	Time Date Name & ID
8Am 10P	<b>Fluid and electrolytes</b> <input type="checkbox"/> Oral <input checked="" type="checkbox"/> IV <input type="checkbox"/> Ryles Tube Feed <input type="checkbox"/> TPN <input type="checkbox"/> Others	<input type="checkbox"/> Patient will have balanced fluid and electrolyte balance	<ul style="list-style-type: none"> <li>● Monitor intake and output chart</li> <li>● Check for IV sites, patency and monitor for any signs of phlebitis</li> <li>● Enhance fluid intake unless contraindicated</li> <li>● Fluid <u>DS</u> at <u>60</u></li> </ul>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> Well hydrated. <input type="radio"/> IV cannula is patent and intact. <input type="radio"/> I/O chart _____	<del>BA</del> <del>N3491</del> <del>20</del> <del>15/4/24</del>
8Am 10P	<b>NUTRITION</b> <input type="checkbox"/> Keep NBM <input type="checkbox"/> Full Diet <input type="checkbox"/> Therapeutic Diet <input checked="" type="checkbox"/> Ryles tube feed <input type="checkbox"/> TPN	<input type="checkbox"/> Patient will have adequate nutrition <input type="checkbox"/> Patient will have no nausea and vomiting	<ul style="list-style-type: none"> <li>● Provide prescribed diet on time</li> <li>● Encourage patient to consume the served meal</li> <li>● Record the amount of food consumed</li> <li>● IV Fluid at <u>60</u> ml/hr.</li> <li>● TPN at _____ ml/hr.</li> <li>● RT Feed at <u>60</u> ml/hr.</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> Good appetite <input type="radio"/> No nausea or vomiting <input type="radio"/> Served meal is consumed full/partial/none (tick wherever applicable)	<del>BA</del> <del>N3491</del> <del>20</del> <del>15/4/24</del>
8Am 10P	<b>SKIN INTEGRITY</b> <input type="checkbox"/> Intact skin <input checked="" type="checkbox"/> Skin peel present at Area _____ Grade _____ PUSH Score _____	<input type="checkbox"/> Patient will have intact skin integrity <input type="checkbox"/> Patients skin peel is improving	<ul style="list-style-type: none"> <li>● Assess the Braden score and all potential causes of skin breakdown</li> <li>● Minimize / eliminate friction /shear</li> <li>● Relieve pressure points by using air mattress, prophylactic skin dressing</li> <li>● Manage moisture</li> <li>● Maintain adequate nutrition and hydration</li> <li>● Keep bed wrinkle free</li> <li>● Change position as per position clock</li> </ul>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> No skin breakdown is noted <input type="radio"/> Skin peel is healing/not healing	<del>BA</del> <del>N3491</del> <del>20</del> <del>15/4/24</del>
8Am 10P	<b>HYGIENE</b> <input checked="" type="checkbox"/> Bed bath <input type="checkbox"/> Assist in bath on bed <input checked="" type="checkbox"/> Oral care <input checked="" type="checkbox"/> Perineal care <input type="checkbox"/> Hair wash <input type="checkbox"/> Others _____	<input checked="" type="checkbox"/> Patient will stay clean and well groomed.	<ul style="list-style-type: none"> <li>● Encourage patient / daily give sponge. bath, oral care, hair care and perineal care.</li> <li>● Change patients clothes daily</li> <li>● Encourage hand hygiene as per 5 moments</li> </ul>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> Patient is having good personal hygiene	<del>BA</del> <del>N3491</del> <del>20</del> <del>15/4/24</del>