

Time	Patient Specific Nursing Needs	Measurable Goal	Nursing Interventions	M	E	N	Evaluation / Outcome	Time Date Name & ID
8 ^{AM} 10 ^{AM}	Fluid and electrolytes <input type="checkbox"/> Oral <input checked="" type="checkbox"/> IV <input type="checkbox"/> Ryles Tube Feed <input type="checkbox"/> TPN <input type="checkbox"/> Others	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolyte balance	<ul style="list-style-type: none"> ● Monitor intake and output chart ● Check for IV sites, patency and monitor for any signs of phlebitis ● Enhance fluid intake unless contraindicated ● Fluid <u>DS</u> at <u>800</u> 	<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 type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> Well hydrated. <input type="checkbox"/> IV cannula is patent and intact. <input type="checkbox"/> I/O chart _____	<i>8 AM fluids done</i> <i>10 AM</i>
8 ^{AM} 10 ^{AM}	NUTRITION <input checked="" type="checkbox"/> Keep NBM <input type="checkbox"/> Full Diet <input type="checkbox"/> Therapeutic Diet <input type="checkbox"/> Ryles tube feed <input type="checkbox"/> TPN	<input checked="" type="checkbox"/> Patient will have adequate nutrition <input type="checkbox"/> Patient will have no nausea and vomiting	<ul style="list-style-type: none"> ● Provide prescribed diet on time ● Encourage patient to consume the served meal ● Record the amount of food consumed ● IV Fluid at <u>800</u> ml/hr. ● TPN at _____ ml/hr. ● RT Feed at _____ ml/hr. 	<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="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Good appetite <input checked="" type="checkbox"/> No nausea or vomiting <input type="checkbox"/> Served meal is consumed full/partial/none (tick wherever applicable)	<i>8 AM fluids done</i> <i>10 AM</i>
8 ^{AM} 10 ^{AM}	SKIN INTEGRITY <input type="checkbox"/> Intact skin <input checked="" type="checkbox"/> Skin peel present at Area <u>ear, shoulder</u> Grade _____ PUSH Score _____	<input checked="" type="checkbox"/> Patient will have intact skin integrity <input type="checkbox"/> Patients skin peel is improving	<ul style="list-style-type: none"> ● Assess the Braden score and all potential causes of skin breakdown ● Minimize / eliminate friction /shear ● Relieve pressure points by using air mattress, prophylactic skin dressing ● Manage moisture ● Maintain adequate nutrition and hydration ● Keep bed wrinkle free ● Change position as per position clock 	<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 type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No skin breakdown is noted <input checked="" type="checkbox"/> Skin peel is healing/not healing	<i>8 AM fluids done</i> <i>10 AM</i>
8 ^{AM} 10 ^{AM}	HYGIENE <input type="checkbox"/> Bed bath <input checked="" type="checkbox"/> Assist in bath on bed <input type="checkbox"/> Oral care <input 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"> ● Encourage patient / daily give sponge, bath, oral care, hair care and perineal care. ● Change patients clothes daily ● Encourage hand hygiene as per 5 moments 	<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 type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Patient is having good personal hygiene	<i>8 AM fluids done</i> <i>10 AM</i>