

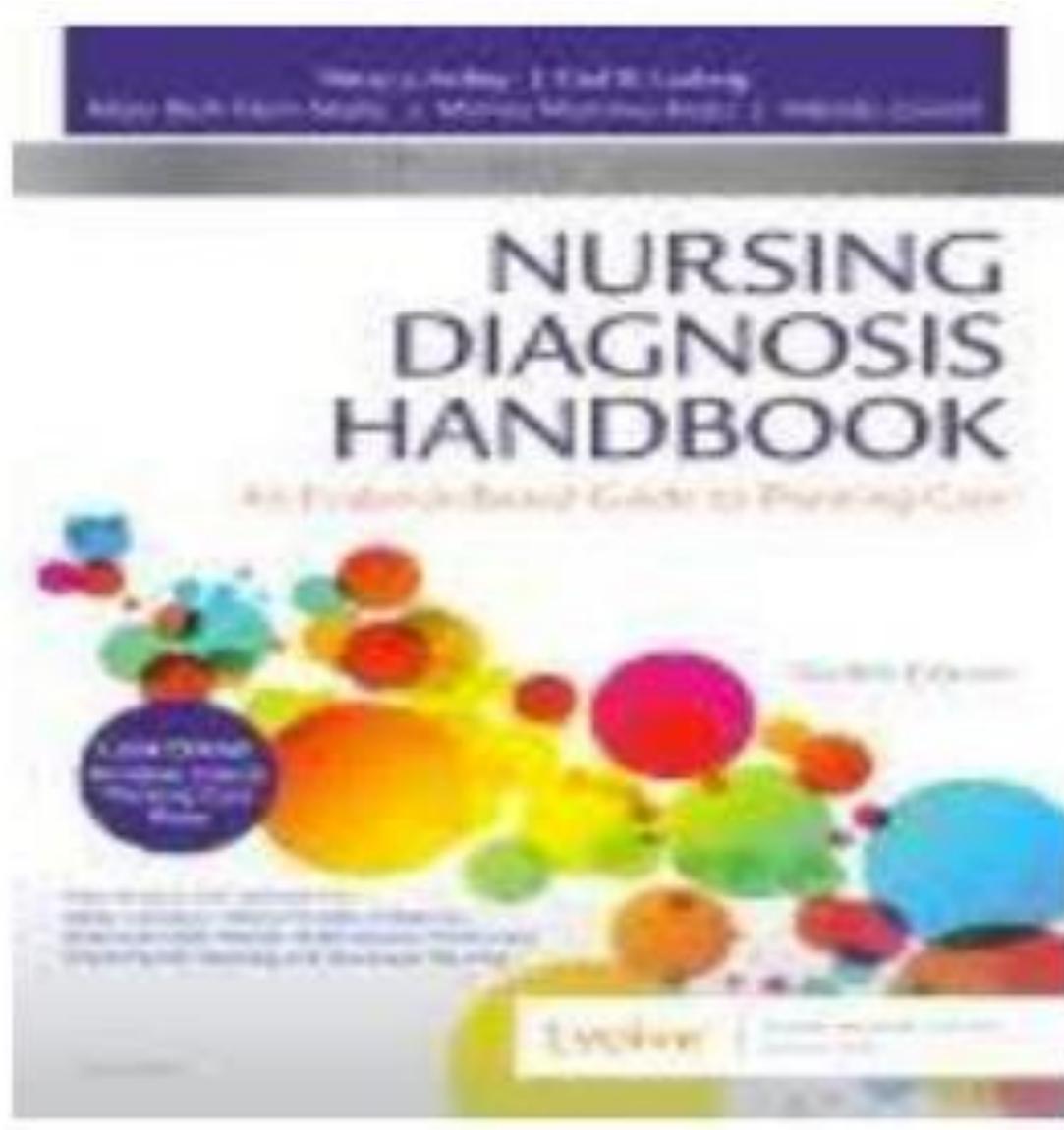
# USING THE NURSING DIAGNOSIS BOOK & COMPLETING THE NURSING CAREPLAN SUMMER SEMESTER

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Audra Xenakis, DNP, RN

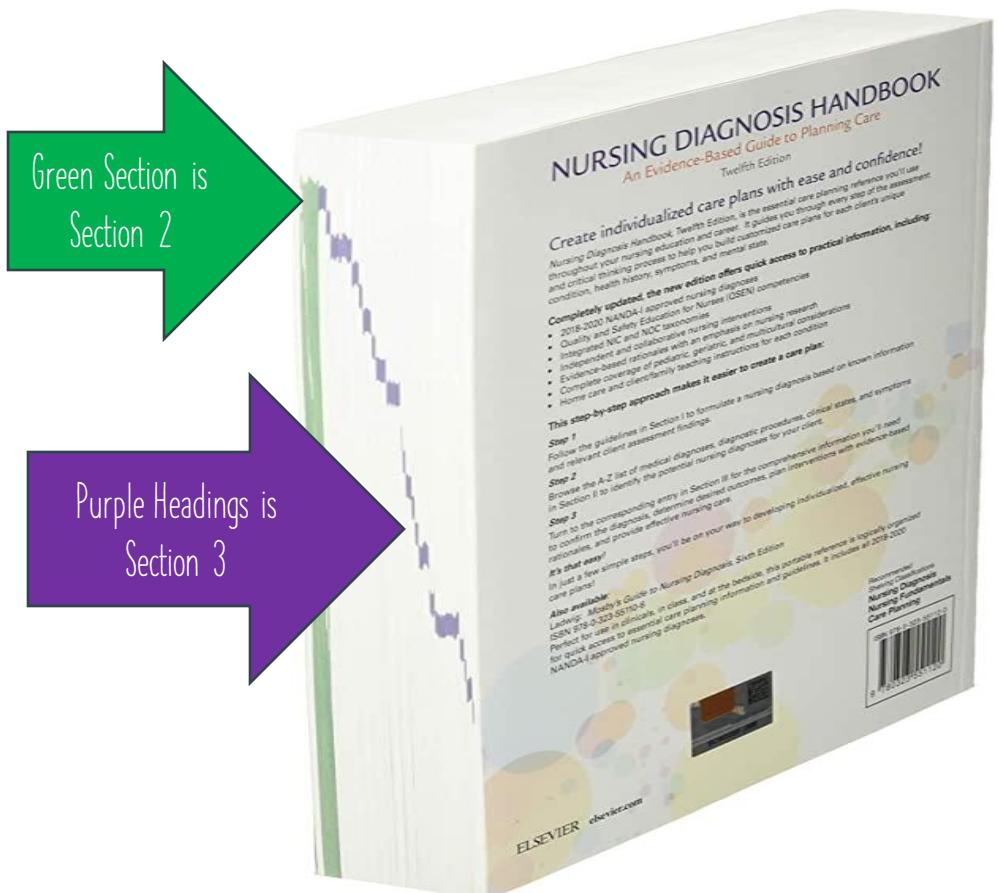
# THE NURSING DIAGNOSIS BOOK

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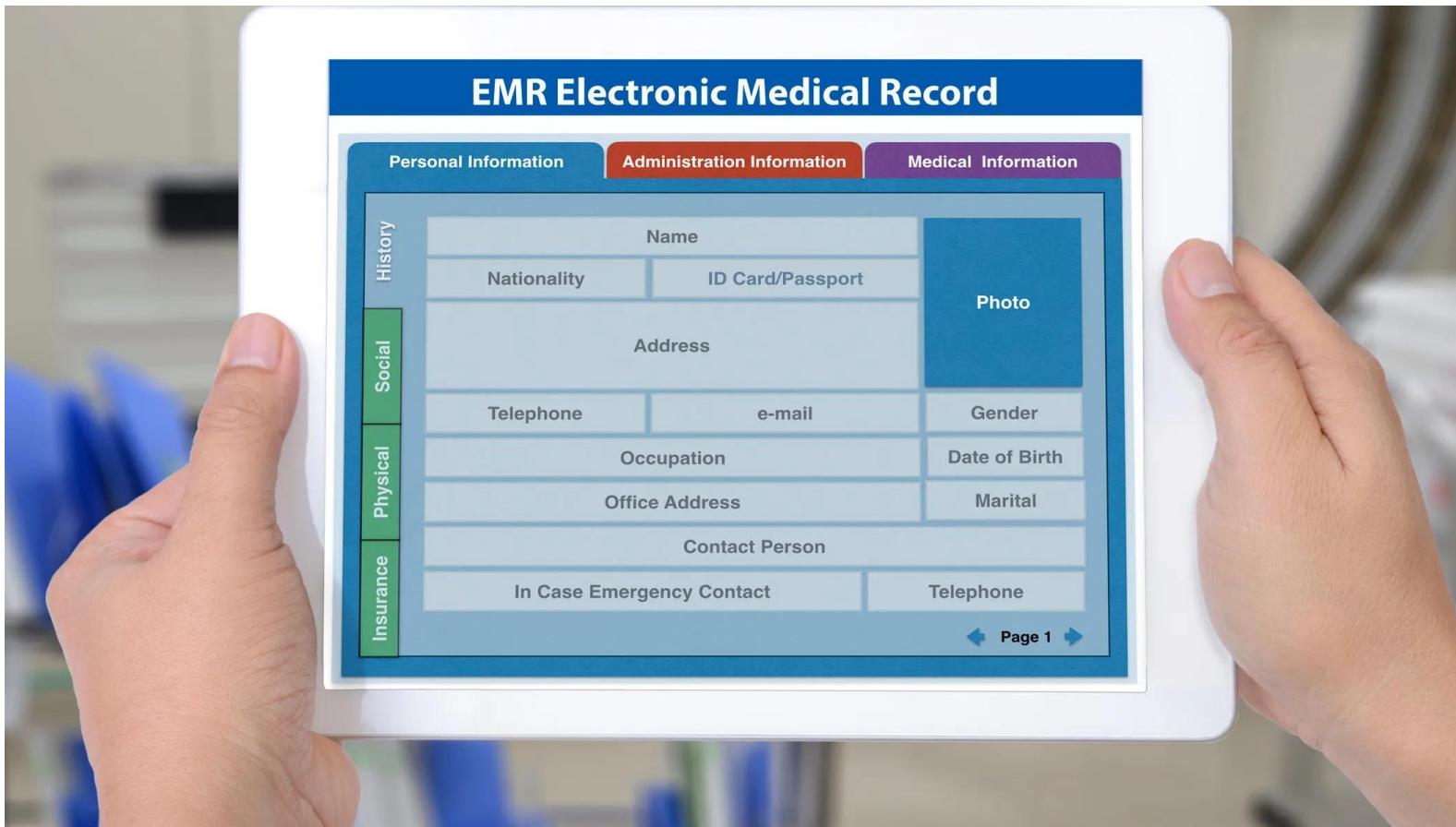
# SECTIONS OF NURSING DIAGNOSIS BOOK

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# HOW DO YOU KNOW WHAT THE PATIENT'S MEDICAL DIAGNOSIS IS?

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ONCE YOU FIND THE MEDICAL DIAGNOSIS...  
DETERMINE WHICH NURSING DIAGNOSIS  
BEST REFLECTS YOUR PATIENT



# HOW DO YOU KNOW WHICH NURSING DIAGNOSIS TO CHOOSE?

---

Temple College Vocational Nursing Program  
VNSG 1260 Clinical I

Name: Click or tap here to enter text.  
Date: Click or tap here to enter text.

## Client Nursing Process

Demographics			
Patient's initials		Age	
Code Status		Gender	
Allergies			
Isolation	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> contact <input type="checkbox"/> extended contact <input type="checkbox"/> droplet <input type="checkbox"/> airborne <input type="checkbox"/> neutropenic		
Date of Admission			
Admitting Diagnosis			
Reason for admission (client's own words)			
Medical History			
Surgical History			
Psychosocial/ Communication			
Marital Status		Significant Others	
Highest level of education		Occupation	
Primary Language		Does client/family understand English?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client able to:			
Read	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Write	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Speak Understandably	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Communicate Basic Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Does the client have:			
Hearing impairment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aids: <input type="checkbox"/> Yes <input type="checkbox"/> No	

# HOW DO YOU KNOW WHICH NURSING DIAGNOSIS TO CHOOSE?

---

Temple College Vocational Nursing Program  
VNSG 1260 Clinical I

Name: Click or tap here to enter text.  
Date: Click or tap here to enter text.

## Client Nursing Process

Demographics			
Patient's initials		Age	
Code Status		Gender	
Allergies			
Isolation	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> contact <input type="checkbox"/> extended contact <input type="checkbox"/> droplet <input type="checkbox"/> airborne <input type="checkbox"/> neutropenic		
Date of Admission			
Admitting Diagnosis			
Reason for admission (client's own words)			
Medical History			
Surgical History			
Psychosocial/ Communication			
Marital Status		Significant Others	
Highest level of education		Occupation	
Primary Language		Does client/family understand English?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client able to:			
Read	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Write	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Speak Understandably	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Communicate Basic Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:	
Does the client have:			
Hearing impairment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aids: <input type="checkbox"/> Yes <input type="checkbox"/> No	

# WHAT DOES THE NURSING CAREPLAN LOOK LIKE DURING THE SUMMER SEMESTER?

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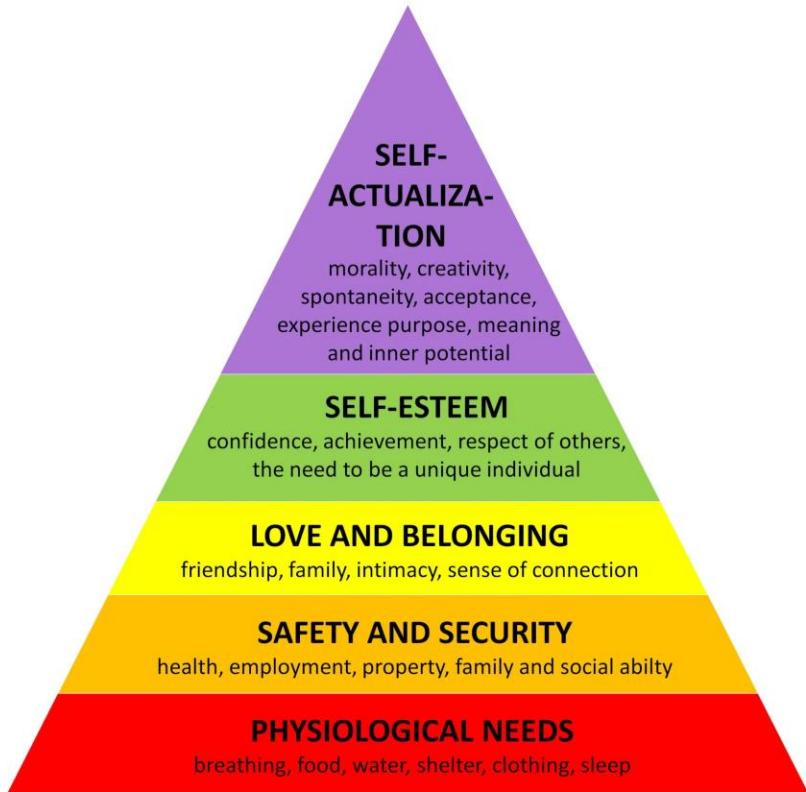
Temple College Vocational Nursing Program  
VNSG 1260 Clinical I

Name: Click or tap here to enter text.  
Date: Click or tap here to enter text.

Client Nursing Process <i>Thinking Like a Nurse</i>			
	Prioritization	What client Issue was identified during assessment? <i>One-part Nursing Diagnosis</i>	What data did you collect from your assessment that supports the identified issue/ concern?
1	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		<i>Subjective (1):</i>  <i>Objective (2):</i>
2	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		<i>Subjective (1):</i>  <i>Objective (2):</i>
3	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		<i>Subjective (1):</i>  <i>Objective (2):</i>

# HOW TO DETERMINE THE PRIORITY OF NURSING DIAGNOSIS

---



Low?

Medium?

High?

# IDENTIFIED CLIENT ISSUE DURING YOUR NURSING ASSESSMENT

Thinking Like a Nurse			
	Prioritization	What client issue was identified during assessment? One-part Nursing Diagnosis	What data did you collect from your assessment that supports the identified issue/ concern?
1	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<b>Risk for Urinary Tract Injury</b>	<p>Subjective (1): pt states she doesn't drink enough water. Pt states, "Don't really like drinking water since I have to change my pad."</p> <p>Objective (2): Cup full of water. Dry skin.</p>
2	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<b>Excess Fluid Volume</b>	<p>Subjective (1): When mentioning her edema on <u>lower legs</u> pt <u>stated</u>, she doesn't go on walks.</p> <p>Objective (2): Indention of socks. Pitting 2+, lower legs B, weak Dorsalis Pedis pulse B.</p>
3	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<b>Risk for Injury</b>	<p>Subjective (1): pt states she has trouble balancing and has macular degeneration.</p> <p>Objective (2): Pt wears magnifying glass to see text. Pt unable to accommodate eyes when doing PERRLA.</p>

# SUPPORTIVE DATA TYPES

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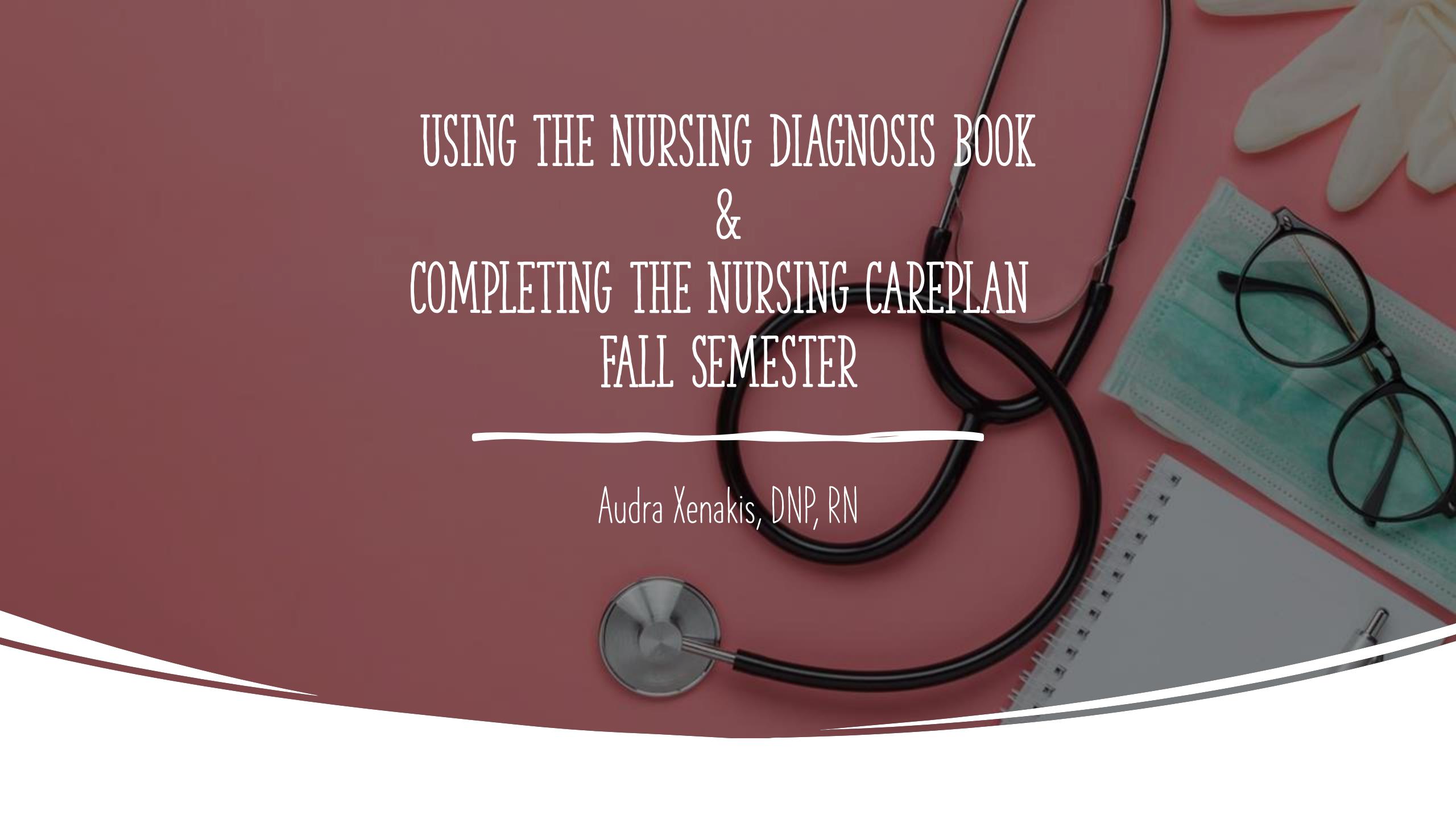
- Subjective
- Objective

# WHAT DATA WAS COLLECTED DURING ASSESSMENT THAT SUPPORTS THE IDENTIFIED ISSUE?

## Client Nursing Process

### Thinking Like a Nurse

Client Nursing Process			
Thinking Like a Nurse			
	Prioritization	What client issue was identified during assessment? <i>One-part Nursing Diagnosis</i>	What data did you collect from your assessment that supports the identified issue/concern?
1	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<b>Risk for Urinary Tract Injury</b>	<p>Subjective (1): pt states she doesn't drink enough water. Pt states, "Don't really like drinking water since I have to change my pad."</p> <p>Objective (2): Cup full of water. Dry skin.</p>
2	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<b>Excess Fluid Volume</b>	<p>Subjective (1): When mentioning her edema on <u>lower legs</u> pt stated, she doesn't go on walks.</p> <p>Objective (2): Indention of socks. Pitting 2+, lower legs B, weak Dorsalis Pedis pulse B.</p>
3	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<b>Risk for Injury</b>	<p>Subjective (1): pt states she has trouble balancing and has macular degeneration.</p> <p>Objective (2): Pt wears magnifying glass to see text. Pt unable to accommodate eyes when doing PERRLA.</p>



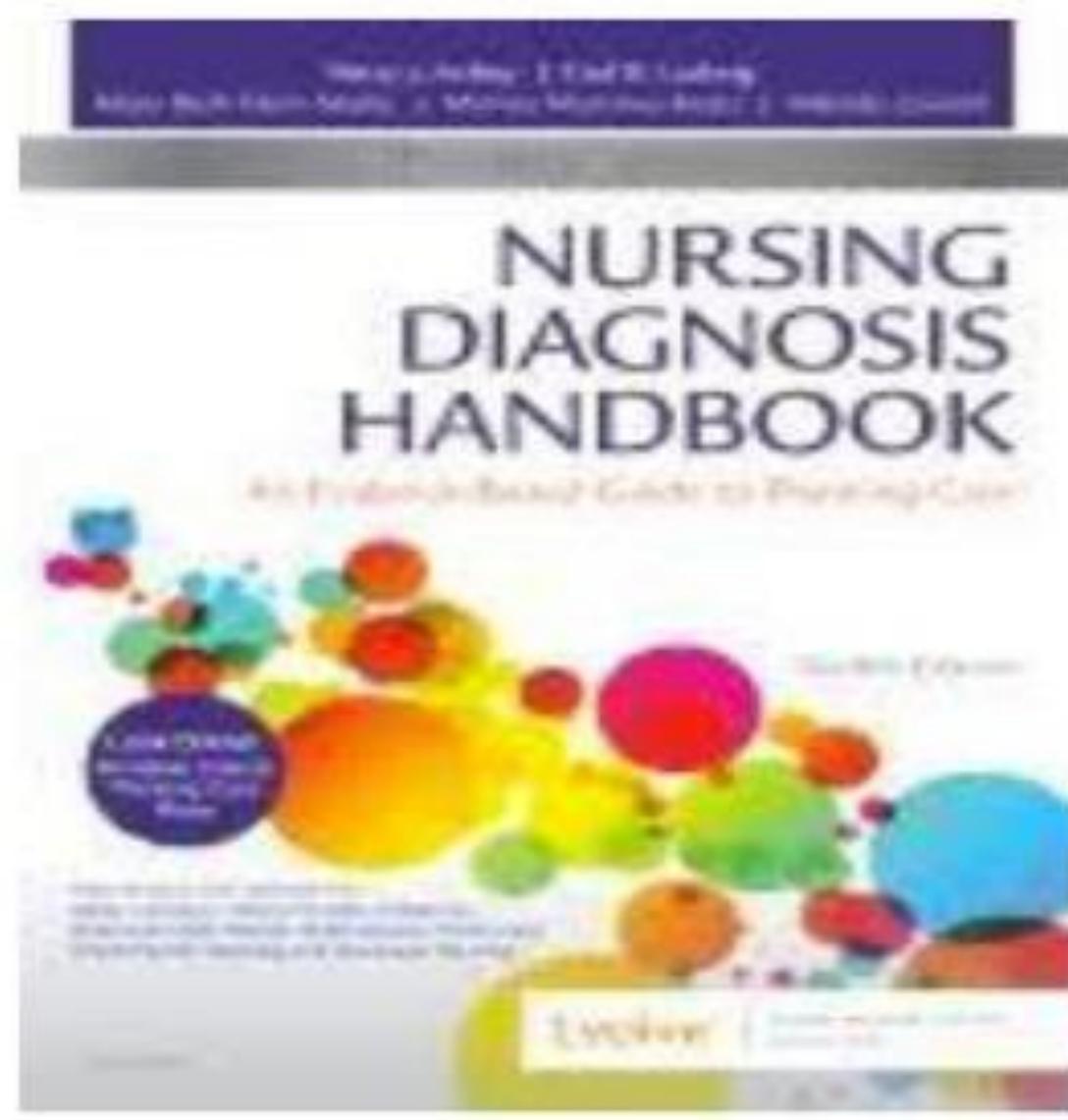
# USING THE NURSING DIAGNOSIS BOOK & COMPLETING THE NURSING CAREPLAN FALL SEMESTER

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Audra Xenakis, DNP, RN

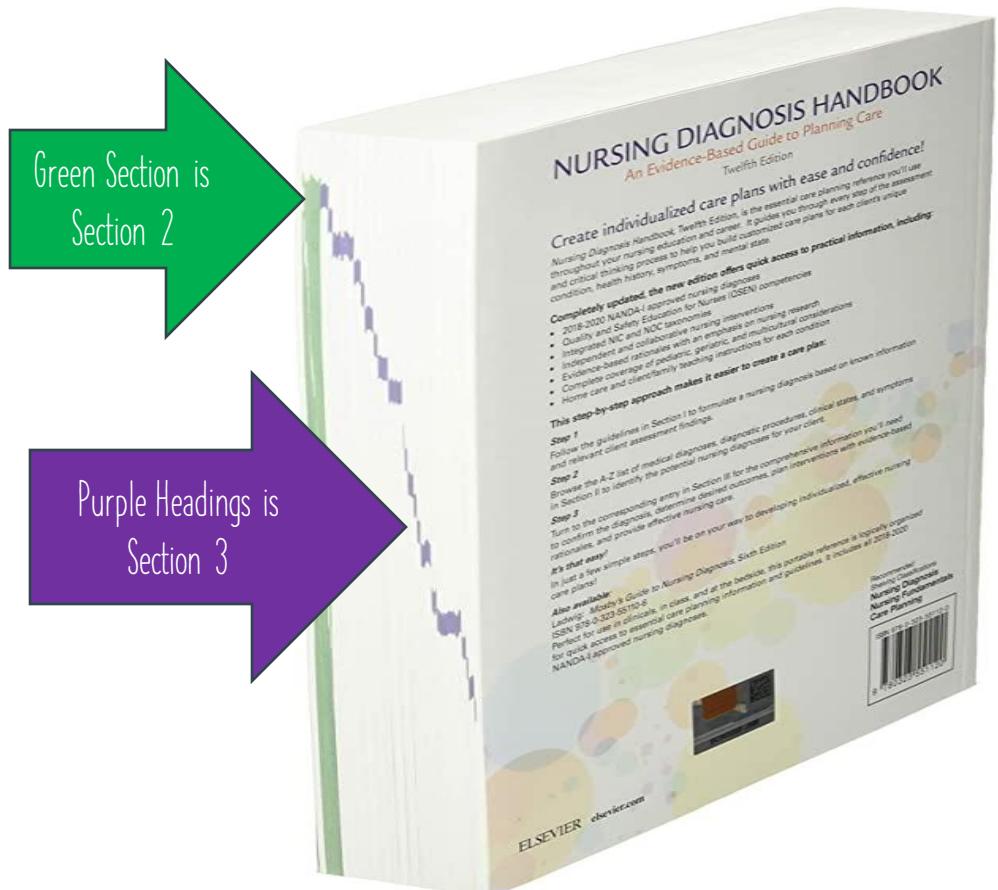
# THE NURSING DIAGNOSIS BOOK

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# SECTIONS OF NURSING DIAGNOSIS BOOK

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Steps:

1. Front: Green Section
2. Back: Index
3. Middle: Purple for Nursing Diagnosis (Careplan)

# WHAT DATA WAS COLLECTED DURING THE ASSESSMENT THAT SUPPORTS THE IDENTIFIED ISSUE/PROBLEM?

Temple College Vocational Nursing Program  
VNSG 1260 Clinical I

Name: Click or tap here to enter text.  
Date: Click or tap here to enter text.

## Client Nursing Process

Demographics		
Patient's initials		Age
Code Status		Gender
Allergies		
Isolation	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> contact <input type="checkbox"/> extended contact <input type="checkbox"/> droplet <input type="checkbox"/> airborne <input type="checkbox"/> neutropenic	
Date of Admission		
Admitting Diagnosis		
Reason for admission (client's own words)		
Medical History		
Surgical History		
Psychosocial/ Communication		
Marital Status		Significant Others
Highest level of education		Occupation
Primary Language		Does client/family understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client able to:		
Read	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:
Write	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:
Speak Understandably	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:
Communicate Basic Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evidence:
Does the client have:		
Hearing impairment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aids: <input type="checkbox"/> Yes <input type="checkbox"/> No

# WHAT DID THE NURSING DIAGNOSIS/CAREPLAN LOOK LIKE DURING THE SUMMER SEMESTER?

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Client Nursing Process			
Thinking Like a Nurse			
	Prioritization	What client issue was identified during assessment? <i>One-part Nursing Diagnosis</i>	What data did you collect from your assessment that supports the identified issue/ concern?
1	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		<i>Subjective (1):</i>
			<i>Objective (2):</i>
2	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		<i>Subjective (1):</i>
			<i>Objective (2):</i>
3	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		<i>Subjective (1):</i>
			<i>Objective (2):</i>

# WHAT DOES THE NURSING DIAGNOSIS/CAREPLAN LOOK LIKE FOR THE FALL SEMESTER?

<b>ASSESSMENT:</b> Client Data (What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)	<b>Nursing Diagnosis Statement (NANDA Approved)</b>		
Subjective Data: (What did the client say about the issue?)  Last pain scale score: (Date/time) _____	<b>NANDA Label:</b> <b>Acute Pain</b>  Definition: Unpleasant sensations associated with actual or potential damage (Internationally, slow onset of any int predictable end, and	<b>Priority According to Maslow:</b> (Circle one) HIGH	<b>IMPLEMENTATION:</b> (Document how you implemented the intervention and the client's response if you were unable to implement the intervention, state that, and why.)
Objective Data: (What information, [lab values, vital signs, etc.] do you have about the issue?)  Related to: (Etiology) <ul style="list-style-type: none"> <li>• Biological</li> <li>• Chemical</li> <li>• Physical i</li> <li>• Other: _____</li> </ul>	<b>As Manifested</b>	<b>PLANNING: Interventions</b> (Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.) <ul style="list-style-type: none"> <li><input type="checkbox"/> Assess if the client is able to provide a self-report of pain intensity, and if so, assess pain intensity level using a valid and reliable self-report of pain tool, such as the 0 to 10 numerical pain rating scale. <i>Self-report is considered the single most reliable indicator of pain presence and intensity, and single-dimension pain ratings are valid and reliable as measures of pain intensity level (Ackley, Ladwig, &amp; Makic, 2020).</i></li> <li><input type="checkbox"/> Using a self-report pain tool, ask the client to identify a comfort-function goal that will allow the client to perform necessary or desired activities easily. <i>The comfort-function goal provides the basis for individualized pain management plans and assists in determining effectiveness of pain management interventions (Ackley, et al., 2020).</i></li> <li><input type="checkbox"/> Explain to the client the pain management approach, including pharmacological and nonpharmacological interventions, the assessment and reassessment process, potential side effects, and the importance of prompt reporting of unrelieved pain. <i>One of the most important steps toward improved control of pain is a better client understanding of the nature of pain, its treatment, and the role the client needs to play in pain control (Ackley, et al., 2020).</i></li> <li><input type="checkbox"/> Administer analgesics around the clock for continuous pain (expected to be present approximately 50% of the day, such as postoperative pain) and as needed (PRN) for intermittent or breakthrough pain. <i>If pain is present most of the day, the use of PRN medications alone will lead to periods of undermedication and poor pain control and periods of excessive medication and adverse effects (Ackley, et al., 2020).</i></li> <li><input type="checkbox"/> Choose analgesic and dose based on orders that reflect the client's report of pain severity and response to the previous doses in terms of pain relief, occurrence of side effects, and ability to perform the activities of recovery or ADLs. <i>Safe and effective pain management requires opioid dose adjustment based on individualized adequate pain and sedation assessment, opioid administration, and evaluation of the response to treatment (Ackley, et al., 2020).</i></li> <li><input type="checkbox"/> _____</li> </ul>	
<b>PLANNING: Client Outcome</b>  Outcome (Only one behavior/response. Needs to be specific, observable, measurable, achievable, realistic and timed for THIS client.)			
The client will: <ul style="list-style-type: none"> <li>• Perform activities of recovery or activities of daily living (ADLs) easily.</li> <li>• Report pain at a 3 or less on the 0 – 10 scale.</li> <li>• Identify 2 nonpharmacological methods than can be used to help achieve pain goal of 3 or less on the 0 – 10 scale.</li> <li>• _____</li> </ul>	<b>EVALUATION of OUTCOME:</b> (Documented in a Nurse's Note) _____ _____ _____ _____ _____		

# WHICH NURSING DIAGNOSIS SHOULD I USE FOR THE FALL SEMESTER?



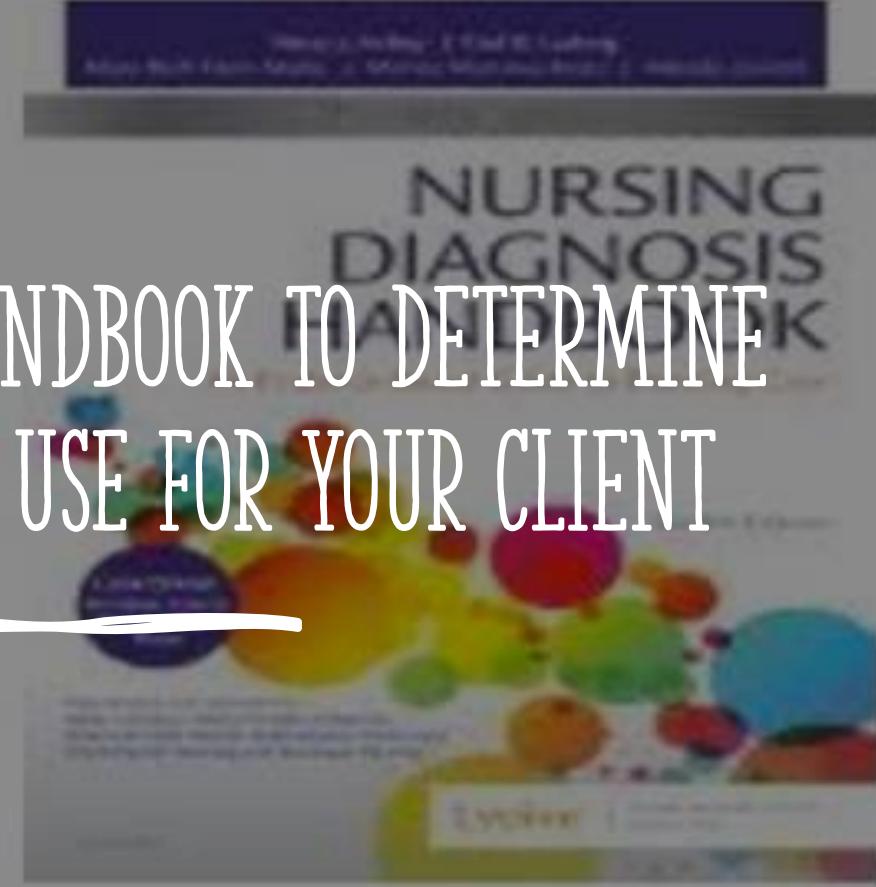
Temple College VN Program Fall NANDA Templates

1. Acute Pain	2. Impaired Physical Mobility
3. Constipation	4. Impaired Skin Integrity
5. Decreased Cardiac Output	6. Impaired Swallowing
7. Deficient Fluid Volume	8. Impaired Tissue Integrity
9. Deficient Knowledge	10. Ineffective Breathing Pattern
11. Excess Fluid Volume	12. Ineffective Protection
13. Hopelessness	14. Nausea
15. Imbalanced Nutrition: less than body requirements	16. Risk for Infection
17. Impaired Gas Exchange	18. Social Isolation

# PROCESS

## Box 4.1, p. 51

USE THE NURSING DIAGNOSIS HANDBOOK TO DETERMINE  
WHICH NURSING DIAGNOSIS TO USE FOR YOUR CLIENT



## Box 4.1 Correlation of Nursing

# WHERE DO I FIND THESE?

## Found in D2L: Clinical Course

FA2023 Clinical-Lvn Training (VNSG-146...)

Course Home Content Discussions Dropbox Quizzes Classlist Grades Attendance Edit Course

List of NANDA Templates to Choose

Temple College VN Program Fall NANDA Templates

1. Acute Pain	2. Impaired Physical Mobility
3. Constipation	4. Impaired Skin Integrity
5. Decreased Cardiac Output	6. Impaired Swallowing

Search Topics

Overview

Bookmarks

Course Schedule

Table of Contents 60

Course Outline 1

Clinical Roster and Schedule

Fall Frontloading Schedule 1

Clinical Assignments 14

NANDA Templates 19

Self-Evaluation Tool 3

Clinical Assignments

Add dates and restrictions...

Add a description...

New Add Existing Activities Bulk Edit

Clinical Assignments and Due Dates PDF document

Vital Signs, BMI and Braden Scale Resource PDF document

Common Abbreviations and Abbreviations of Common Medical Conditions PDF document

Nursing Process Word Document

Nursing Process - Rubric PDF document

Clinical Assignments and Due Dates

Vital Signs, BMI and Braden Scale Resource

Common Abbreviations and Abbreviations of Common Medical Conditions

Nursing Process

Nursing Process - Rubric

# WHERE DO I FIND THESE? Found in D2L: Clinical Course

The screenshot shows the D2L Learning Management System interface for the course "FA2023 Clinical-Lvn Training (VNSG-146...)".

**Course Home:** FA2023 Clinical-Lvn Training (VNSG-146...)

**Navigation Bar:** Course Home, Content, Discussions, Dropbox, Quizzes, Classlist, Grades, Attendance, Edit.

**Left Sidebar:**

- Search Topics
- Overview
- Bookmarks
- Course Schedule
- Table of Contents (60)
- Course Outline (1)
- Clinical Roster and Schedule
- Fall Frontloading Schedule (1)
- Clinical Assignments (14)
- NANDA Templates (19) **(highlighted)**
- Self-Evaluation Tool (3)

**Middle Section:** Clinical Assignments

- Add dates and restrictions...
- Add a description...
- New, Add Existing Activities, Bulk Edit
- [Clinical Assignments and Due Dates](#) (PDF document)
- [Vital Signs, BMI and Braden Scale Resource](#) (PDF document)
- [Common Abbreviations and Abbreviations of Common Medical Conditions](#) (PDF document)
- [Nursing Process](#) (Word Document)
- [Nursing Process - Rubric](#) (PDF document)

**Right Section:** NANDA Templates

- Add dates and restrictions...
- New, Add Existing Activities, Bulk Edit
- [List of NANDA Templates - F23](#) (PDF document)
- [Acute Pain](#) (Word Document)
- [Constipation](#) (Word Document)
- [Decreased Cardiac Output](#) (Word Document)
- [Deficient Fluid Volume](#) (Word Document)
- [Deficient Knowledge](#)

A large blue callout bubble points from the bottom right towards the "NANDA Templates" section, containing the text: "Nursing Diagnosis to choose from".

# STEP 1:

<b>ASSESSMENT: Client Data</b> (What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)		<b>Nursing Diagnosis Statement (NANDA Approved)</b>	
<b>Subjective Data:</b> (What did the client say about the issue?)  Last pain scale score: (Date/time) _____	<b>NANDA Label:</b> <b>Acute Pain</b> <p><i>Definition: Unpleasant sensory and emotional experience associated with actual or potential tissue damage. (International Association for the Study of Pain) Acute pain is generally sudden in onset, has a sharp quality, and a predictable end, and with a duration of less than 3 months.</i></p> <p><b>Related to:</b> (Etiology: Pick one. This is what you will develop the outcome to address.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Biological injury agent</li> <li><input type="checkbox"/> Chemical injury agent</li> <li><input type="checkbox"/> Physical injury agent</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>As Manifested by:</b> (These are the signs and/or symptoms that prove the NANDA Label is a problem.)</p> <p><i>What is the problem related to the identified problem???</i></p> <p><i>What are the signs and symptoms related to the identified problem???</i></p>		
<b>PLANNING: Client Outcome</b> <b>Outcome</b> (Only one behavior/response. Needs to be specific, observable, measurable, achievable, realistic, and timed for THIS client.)	<b>Time</b> (When you expect the response to occur. If there is an agency policy for reassessment, such as within 24 hours, utilize that time frame in your outcome to add it to your workflow.)		
<b>The client will:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Perform activities of recovery or activities of daily living (ADLs) easily.</li> <li><input type="checkbox"/> Report pain at a 3 or less on the 0 – 10 scale.</li> <li><input type="checkbox"/> Identify 2 nonpharmacological methods than can be used to help achieve pain goal of 3 or less on the 0 – 10 scale.</li> <li><input type="checkbox"/> _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> By the end of hospital day ____ (<b>1, 2, 3?</b>)</li> <li><input type="checkbox"/> within ____ minutes of administration of ____ (medication)</li> <li><input type="checkbox"/> by discharge / transfer (circle one)</li> <li><input type="checkbox"/> _____</li> </ul>		

# STEP 2:

ASSESSMENT: Client Data (What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)		Nursing Diagnosis Statement (NANDA Approved)	
<b>Subjective Data:</b> (What did the client say about the issue?)  Last pain scale score: (Date/time) _____		<b>NANDA Label:</b> <b>Acute Pain</b>	<b>Priority According to Maslow:</b> (Circle one)  <b>HIGH</b>  <b>MEDIUM</b>  <b>LOW</b>
<b>Objective Data:</b> (What information, lab values, vital signs do you have about the issue?)  The client will perform activities of recovery or activities of daily living (ADLs) easily by the end of hospital day 3.		associated with sudden or anticipated or	develop the outcome to address.
<p><b>As Manifested By:</b> (These are the signs and/or symptoms that prove the NANDA Label is a problem.)</p> <p>Pick 1 of the outcome options that the client will achieve</p> <p>Chose 1 of the time options that the client will achieve</p>			
<b>PLANNING: Client Outcome</b>		<b>Outcome</b> (Only one behavior/response. Needs to be measurable, achievable, realistic, and timed for THIS client.) <b>Time</b> (When you expect the response to occur. For reassessment, such as with pain, utilize that time to add)	
<b>The client will:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Perform activities of recovery or activities of daily living (ADLs) easily.</li> <li><input type="checkbox"/> Report pain at a 3 or less on the 0 – 10 scale.</li> <li><input type="checkbox"/> Identify 2 nonpharmacological methods than can be used to help achieve pain goal of 3 or less on the 0 – 10 scale.</li> <li><input type="checkbox"/></li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> By the end of hospital day _____ (<b>1, 2, 3?</b>)</li> <li><input type="checkbox"/> within _____ minutes of administration of _____ (medication)</li> <li><input type="checkbox"/> by discharge / transfer (circle one)</li> <li><input type="checkbox"/> _____</li> </ul>	

# STEP 3:

<b>PLANNING: Interventions</b> (Select interventions that <u>help the client achieve the outcome</u> . Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)	<b>IMPLEMENTATION:</b> ( <u>Document how you implemented the intervention and the client's response</u> If you were unable to implement the intervention, state that, and why.)
<input type="checkbox"/> Assess if the client is able to provide a self-report of pain intensity, and if so, assess pain intensity level using a valid and reliable self-report of pain tool, such as the 0 to 10 numerical pain rating scale. <i>Self-report is considered the single most reliable indicator of pain presence and intensity, and single-dimension pain ratings are valid and reliable as measures of pain intensity level (Ackley, Ladwig, &amp; Makic, 2020).</i>	
<input type="checkbox"/> Using a self-report pain tool, ask the client to perform necessary or desired activities. <i>This identifies a comfort-function goal that will allow the client to perform necessary or desired activities more easily. The comfort-function goal provides the basis for individualized pain management.</i>	
<input type="checkbox"/> Explain to the client the pain management process, pharmacological and nonpharmacological interventions, side effects, and the importance of pain assessment. <i>This is important steps toward improved control of pain, its treatment, and the role the client needs to play in pain management.</i>	
<input type="checkbox"/> Administer analgesics around the clock for continuous pain (expected to be present approximately 50% of the day, such as postoperative pain) and as needed (PRN) for intermittent or breakthrough pain. <i>If pain is present most of the day, the use of PRN medications alone will lead to periods of undermedication and poor pain control and periods of excessive medication and adverse effects (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Choose analgesic and dose based on orders that reflect the client's report of pain severity and response to the previous doses in terms of pain relief, occurrence of side effects, and ability to perform the activities of recovery or ADLs. <i>Safe and effective pain management requires opioid dose adjustment based on individualized adequate pain and sedation assessment, opioid administration, and evaluation of the response to treatment (Ackley, et al., 2020).</i>	
<input type="checkbox"/>	
<b>EVALUATION of OUTCOME: (Documented in a Nurse's Note)</b>	

<b>PLANNING: Interventions</b> ( <i>Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.</i> )	<b>IMPLEMENTATION:</b> ( <i>Document how you implemented the intervention and the client's response If you were unable to implement the intervention, state that, and why.</i> )
<input type="checkbox"/> Assess if the client is able to provide a self-report of pain intensity, and if so, assess pain intensity level using a valid and reliable self-report of pain tool, such as the 0 to 10 numerical pain rating scale. <i>Self-report is considered the single most reliable indicator of pain presence and intensity, and single-dimension pain ratings are valid and reliable as measures of pain intensity level (Ackley, Ladwig, &amp; Makic, 2020).</i>	Assessed pain using a pain scale of 0 to 10. The client was able to self-report pain of 7 out of 10 pain scale.
<input type="checkbox"/> Using a self-report pain tool, ask the client to identify a comfort-function goal that will allow the client to perform necessary or desired activities easily. <i>The comfort-function goal provides the basis for individualized pain management interventions and assists in determining effectiveness of pain management interventions (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Explain to the client the pain management process, including pharmacological and nonpharmacological interventions, potential side effects, and the importance of understanding the nature of pain, its treatment, and the role the client can play in managing pain. <i>One of the most important steps toward improved control of pain is for the client to understand the assessment process, potential side effects, and the importance of understanding the nature of pain, its treatment, and the role the client can play in managing pain (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Administer analgesics around the clock, as needed, approximately 50% of the day, such as acetaminophen, ibuprofen, or naproxen, to manage intermittent or breakthrough pain. <i>If pain is present for more than 24 hours a day, the use of PRN medications alone will lead to periods of undermedication, poor pain control and periods of excessive medication and adverse effects (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Choose analgesic and dose based on orders that reflect the client's report of pain severity and response to the previous doses in terms of pain relief, occurrence of side effects, and ability to perform the activities of recovery or ADLs. <i>Safe and effective pain management requires opioid dose adjustment based on individualized adequate pain and sedation assessment, opioid administration, and evaluation of the response to treatment (Ackley, et al., 2020).</i>	
<input type="checkbox"/>	
<b>EVALUATION of OUTCOME:</b> ( <i>Documented in a Nurse's Note</i> )	

# STEP 4:

PLANNING: Interventions (Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)	IMPLEMENTATION: (Document how you implemented the intervention and the client's response If you were unable to implement the intervention, state that outcome.)
<input type="checkbox"/> Assess if the client is able to provide a self-report of pain intensity, and if so, assess pain intensity level using a valid and reliable self-report of pain tool, such as the 0 to 10 numeric rating scale (NRS) or visual analog scale (VAS), as a reliable indicator of pain as measure.	
<input type="checkbox"/> Using the client's self-report, provide effective nonpharmacological interventions to manage pain.	
<input type="checkbox"/> Explain nonpharmacological side effects of pain medication and its impact on pain.	
<input type="checkbox"/> Administer analgesics around the clock for continuous pain (expected to be approximately 50% of the day, such as postoperative pain) and as needed for intermittent or breakthrough pain. <i>If pain is present most of the day, the use of PRN medications alone will lead to periods of undermedication and poor pain control, which can lead to excessive medication and adverse effects (Ackley et al., 2020).</i>	
<input type="checkbox"/> Choose analgesic and dose based on ordered pain assessment and response to the previous doses in terms of pain relief and ability to perform the activities of recovery. <i>It is important to remember that opioid dose adjustment based on individual patient needs, rather than fixed doses, is required to manage pain effectively, reduce adverse effects, and ensure safe management of pain.</i>	
<input type="checkbox"/>	
EVALUATION of OUTCOME: (Document the outcome in a Nurse's Note)	
August 2, 2023, 0900 The client was able to perform activities of recovery or activities of daily living (ADLs) easily by the end of hospital day 3. Goal met. A. Xenakis, TC SVN ---	

The Client Outcome (Goal) is:

The client will perform activities of recovery or activities of daily living (ADLs) easily by the end of hospital day 3.

- Document as a Nurse's Note:
- Use the Client Outcome/Goal from page 1!!!
  - Date & Time
  - Restate the Client Outcome Goal and identify whether the goal was achieved or not
  - Provide recommendation of either:
    - Goal met. OR Goal not met. Recommend continuing goal.
    - Signature and credential!!!

Evaluate whether the Outcome/Goal was achieved OR not achieved



LET'S TRY IT!

# MRS. MARTINEZ

---

The nurse admits a 70-year-old obese female client who had a stroke a week ago at the nursing home where she lives. The nurse performs a head-to-toe assessment at the rehabilitation unit. The client has right-sided weakness from the stroke, urinary incontinence, a history of diabetes mellitus, and early dementia.

She can communicate in short sentences but has trouble understanding what staff or family is saying. During the nursing assessment, a stage 1 pressure injury is noted over the client's sacral bone involving the epidermal and dermal tissue. The skin is red, intact, and 3 inches in diameter. The client states, "I have difficulty walking, so I sit or lay down most of the day."

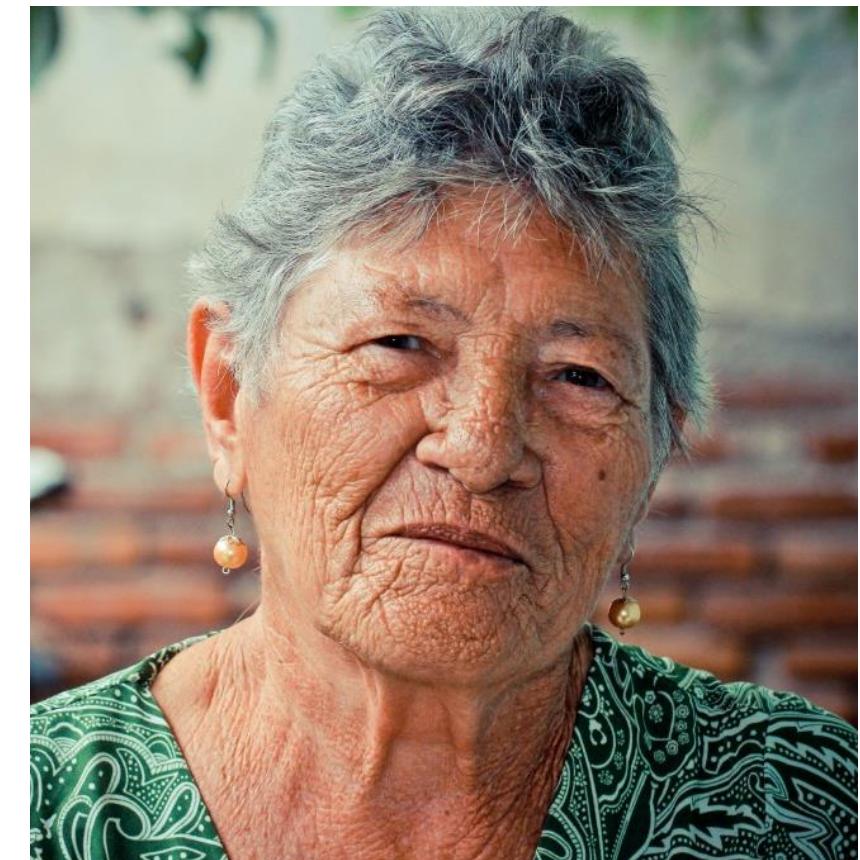


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## Temple College VN Program Fall NANDA Templates

1. Acute Pain	2. Impaired Physical Mobility
3. Constipation	4. Impaired Skin Integrity
5. Decreased Cardiac Output	6. Impaired Swallowing
7. Deficient Fluid Volume	8. Impaired Tissue Integrity
9. Deficient Knowledge	10. Ineffective Breathing Pattern
11. Excess Fluid Volume	12. Ineffective Protection
13. Hopelessness	14. Nausea
15. Imbalanced Nutrition: less than body requirements	16. Risk for Infection
17. Impaired Gas Exchange	18. Social Isolation

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<p><b>ASSESSMENT: Client Data</b> (What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)</p> <p><b>Subjective Data:</b> (What did the client say about the issue?)</p> <p><b>Objective Data:</b> (What information, [lab values, vital signs, etc.] do you have about the issue?)</p>	<p style="text-align: center;"><b>Nursing Diagnosis Statement (NANDA Approved)</b></p> <p><b>NANDA Label:</b> <b>Impaired Skin Integrity</b></p> <p><i>Definition: Alteration of epidermal and/or dermal tissue.</i></p> <p><b>Priority According to Maslow:</b> (Circle one) <b>HIGH</b> <b>MEDIUM</b> <b>LOW</b></p> <p><b>Related to:</b> (Etiology: Pick one. This is what you will develop the outcome to address.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Inadequate nutrition</li> <li><input type="checkbox"/> Pressure injury over bony prominence</li> <li><input type="checkbox"/> Alteration in skin moisture</li> <li><input type="checkbox"/> Impaired circulation</li> <li><input type="checkbox"/> Alteration in fluid volume</li> <li><input type="checkbox"/> Decreased sensation</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>As Manifested by:</b> (These are the signs and/or symptoms that prove the NANDA Label is a problem.)</p>
<p><b>PLANNING: Client Outcome</b></p>	<p><b>Outcome</b> (Only one behavior/response. Needs to be specific, observable, measurable, achievable, realistic, and timed for THIS client.)</p> <p><b>Time</b> (When you expect the response to occur. If there is an agency policy for reassessment, such as with pain, utilize that time frame in your outcome to add it to your workflow.)</p>
<p><b>The client will:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Regain integrity of skin surface.</li> <li><input type="checkbox"/> Report any altered sensation or pain at site of skin impairment.</li> <li><input type="checkbox"/> Demonstrate understanding of plan to heal skin and prevent reinjury.</li> <li><input type="checkbox"/> Describe measures to protect, heal the skin and to care for any skin lesion.</li> <li><input type="checkbox"/></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> By the end of hospital day _____</li> <li><input type="checkbox"/> by discharge / transfer (circle one)</li> <li><input type="checkbox"/> _____</li> </ul>

<b>PLANNING: Interventions</b> (Select interventions that <u>help the client achieve the outcome</u> . Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in <i>italics</i> . Rationales for actions must be included.)	<b>IMPLEMENTATION:</b> (Document how you implemented the intervention and the client's response If you were unable to implement the intervention, state that, and why.)
<input type="checkbox"/> Assess the client's nutritional status. Refer for a nutritional consult and/or institute dietary supplements as necessary. <i>Optimizing nutritional intake, including calories, fatty acids, protein, and vitamins, is needed to promote wound healing. Endorse the application of reasonable nutritional assessment and treatment for clients at risk for and with pressure injuries (Ackley, Ladwig &amp; Makic, 2020).</i>	
<input type="checkbox"/> Inspect and monitor site of skin impairment at least once a day for color changes, redness, swelling, warmth, pain, or other signs of infection. Determine whether the client is experiencing changes in sensation or pain. Closely assess high-risk areas such bony prominences, skinfolds, the sacrum and heels. <i>Systematic inspection can identify impending problems early. When conducting a skin assessment in an individual with darkly pigmented skin prioritize assessment of skin temperature, presence of edema and change in tissue consistency in relation to surrounding tissue (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Use a risk assessment tool to systematically assess client risk factors for skin breakdown due to pressure injuries. <i>A validated risk assessment tool such as the Braden and/or Norton scale should be utilized to identify clients at risk for immobility-related skin breakdown. Targeting variables can focus assessment on particular risk factors and help guide the plan of prevention and care (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Do not position the client on site of skin impairment. If consistent with overall client management goals, reposition the client as determined by individualized tissue tolerance and overall condition. <i>Establish turning frequency based on the characteristics of the support surface and the individual's response. If the goal of care is to keep the client comfortable, turning and repositioning may not be appropriate (Ackley, et al., 2020).</i>	
<input type="checkbox"/> Avoid massaging around the site of skin impairment and over bony prominences. <i>Research suggested that massage may lead to deep tissue trauma (Ackley, et al., 2020).</i>	
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<p><b>EVALUATION of OUTCOME: (Documented in a Nurse's Note)</b></p>	



*Everything is hard  
before it is easy.*  
- Goethe