**NURSING DIAGNOSIS:**
- Alteration in tissue perfusion
- Cardiac output, decreased
- Fluid volume excess
- Management of therapeutic regimen, ineffective
- Knowledge deficit (specify: Other (specify))
- Other (specify)

**ONSET**

**PLAN DEVELOPED BY** (Signature/title/date)

<table>
<thead>
<tr>
<th>DESIRED OUTCOMES</th>
<th>TARGET DATE</th>
<th>DATE ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate cardiac output as evidenced by reduction in symptoms and return to baseline vital signs within _______ days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate knowledge of disease process and self-care as evidenced by patient/caregiver verbalization and demonstrations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluids in balance as evidenced by decreased peripheral edema and maintained within 3-4 days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient. Target range: ___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OBSERVATIONS/ASSESSMENTS**
- Vital signs
- Cardiovascular status
- Safety needs
- CG ability to care for patient
- Weight
- Self-care ability
- Mental status
- Other
- Medication response

**TEACH/INSTRUCT**
- Energy conservation with activity
- S/S angina
- Stress management
- S/S disease process
- S/S fluid retention
- S/S complications
- Cardiac diet
- Other
- Coping/Problem solving strategies

**DIRECT CARE**
- Venipuncture
- Refer to other disciplines
- Other

**REVIEWED/REVISED BY** (Signature/title/date)

---

**NURSING DIAGNOSIS:**
- Airway clearance, ineffective
- Gas exchange impaired
- Activity intolerance
- Management of therapeutic regimen, ineffective
- Knowledge deficit (specify: Other (specify))
- Other (specify)

**ONSET**

**PLAN DEVELOPED BY** (Signature/title/date)

<table>
<thead>
<tr>
<th>DESIRED OUTCOMES</th>
<th>TARGET DATE</th>
<th>DATE ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate oxygenation within 1-2 weeks as noted by:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Absence of respiratory complaints.
- Normal breath sounds, respiratory rate and depth.
- Skin color, warm and dry. |  |  |
| Prevention of infection as evidenced by baseline temperature and thin clear sputum within 1-2 weeks. |  |  |
| Increased patient/caregiver knowledge regarding pulmonary disease and care as verbalized and demonstrated within 1-2 weeks. |  |  |
| Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient. Target range: ___________ |  |  |
| Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks. |  |  |
| Other (specify) |  |  |
| Other (specify) |  |  |

**OBSERVATIONS/ASSESSMENTS**
- Vital signs
- Respiratory status
- Safety needs
- CG ability to care for patient
- Weight
- Self-care ability
- Mental status
- Nutritional status
- Medication response

**TEACH/INSTRUCT**
- S/S respiratory infection
- Oxygen usage
- Cough & deep breath
- Suctioning
- Inhalation
- Suctioning
- Tx: hand-held nebulizer
- Disease process
- Other
- Tx: Trach care
- Stoma & cannula
- Other
- Stoma
- Hydration

**DIRECT CARE**
- Admin. trach. care
- Obtain C&S of sputum
- Suctioning
- Vapotherm
- Other
- Cannula

**REVIEWED/REVISED BY** (Signature/title/date)
### GENITOURINARY CARE PLAN

<table>
<thead>
<tr>
<th>NURSING DIAGNOSIS</th>
<th>SKILLED INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Urinary elimination, altered</td>
<td>❑ Vital signs</td>
</tr>
<tr>
<td>❑ Incontinence, total</td>
<td>❑ GU status</td>
</tr>
<tr>
<td>❑ Fluid volume deficit</td>
<td>❑ Safety needs</td>
</tr>
<tr>
<td>❑ Skin integrity impaired, secondary to incontinence</td>
<td>❑ CG ability to care for patient</td>
</tr>
<tr>
<td>❑ Management of therapeutic regimen, ineffective</td>
<td>❑ Weight</td>
</tr>
<tr>
<td>❑ Knowledge deficit (specify)</td>
<td>❑ Mental status</td>
</tr>
<tr>
<td>❑ Other (specify)</td>
<td>❑ Nutritional status</td>
</tr>
</tbody>
</table>

#### DESIRED OUTCOMES

- **Target Date**
- **Date Achieved**

| Patient will demonstrate no S/S infection or urinary catheter complications within 2 weeks. |
| Progressive absence of urinary impairment within 1-2 weeks. |
| Patient/family will comply with self-care needs for urinary elimination within 1-2 weeks (i.e., self-foley care, etc.). |
| Patient/family will verbalize understanding of S/S of complications with subsequent actions within 1 week. |
| Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient. |
| Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks. |
| Other (specify) |

#### OBSERVATIONS/ASSESSMENTS

- Vitals
- GU status
- Safety needs
- CG ability to care for patient
- Weight
- Mental status
- Self-care ability
- Nutritional status
- Medication response
- Fluids and electrolytes

#### TEACH/INSTRUCT

- Importance of adequate fluid intake
- Mgmt. of urinary incont. and care
- Care of Foley catheter
- Aseptic technique
- Perineal hygiene
- Other

#### DIRECT CARE

- Insert/replace Foley catheter
  - Type
  - Balloon size
  - Frequency
- Straight catheterization for residual or to obtain urinalysis culture & sensitivity
- Bladder irrigation
  - Solution
  - Frequency
- Other

####Musculoskeletal CARE PLAN

<table>
<thead>
<tr>
<th>NURSING DIAGNOSIS</th>
<th>SKILLED INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Activity intolerance</td>
<td>❑ Vital signs</td>
</tr>
<tr>
<td>❑ Pain</td>
<td>❑ Integumentary status</td>
</tr>
<tr>
<td>❑ Infection, high risk for</td>
<td>❑ CG ability to care for patient</td>
</tr>
<tr>
<td>❑ Skin integrity, impaired</td>
<td>❑ Weight</td>
</tr>
<tr>
<td>❑ Management of therapeutic regimen, ineffective</td>
<td>❑ Mental status</td>
</tr>
<tr>
<td>❑ Knowledge deficit (specify)</td>
<td>❑ Nutritional status</td>
</tr>
</tbody>
</table>

#### DESIRED OUTCOMES

- **Target Date**
- **Date Achieved**

| Patient/family will verbalize understanding of pt’s safety and mobility needs and demonstrate compliance within 1-2 weeks. |
| Patient will remain safe in home with personal care assistance for 6-9 weeks. |
| Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient. |
| Target range: ___________________ |
| Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks. |
| Other (specify) |

#### OBSERVATIONS/ASSESSMENTS

- Vitals
- GU status
- Safety needs
- CG ability to care for patient
- Weight
- Mental status
- Self-care ability
- Nutritional status
- Medication response
- Fluids and electrolytes
- Integumentary status
- OT referral

#### TEACH/INSTRUCT

- Positioning in bed
- PT referral
- ROM exercises
- Other
- Activity restrictions
- HHA referral

#### DIRECT CARE

- Insert/replace Foley catheter
  - Type
  - Balloon size
  - Frequency
- Straight catheterization for residual or to obtain urinalysis culture & sensitivity
- Bladder irrigation
  - Solution
  - Frequency
- Other
### Integumentary Care Plan

**Nursing Diagnosis:**
- Mobility, impaired physical
- Skin integrity, impaired
- Other (specify)

**Onset**

**Desired Outcomes**

- Skin intact, free from irritation, abrasion, excoriation or disruptions within 1 week.
- Patient/caregiver will verbalize understanding of S/S of integumentary complications with actions to take within 1 week.
- Patient/caregiver will demonstrate appropriate compliance with skin/wound care regimen within 1-3 weeks.
- Therapeutic pharmacological levels achieved as demonstrated through venipuncture by range WNL for patient.
- Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.
- Other (specify)

**Skilled Interventions**

- Vital signs
- Integumentary status
- Safety needs
- CG ability to care for patient
- Weight
- Self-care ability
- Mental status
- Medication response
- Nutritional status
- Fluids and electrolytes
- Wound status
- ET referral
- Pain control
- Wound care per prescribed order
- Pain relief/comfort measures
- Skincare
- Vaginal hygiene
- Wound care procedure to patient/caregiver
- Skin care to prevent further degeneration from fecal/urinary incontinence
- Need to take/recall temp. and relationship to disease process
- Pressure relieving devices
- Measures to decrease pressure points and improve circulation
- Nutrition/Hydration and need for proper maintenance of diet in healing process
- Infection control measures relative to wound care
- Other (specify)

**Teach/Instruct**

- S/S wound infection
- Repositioning in bed & rationale
- Skincare
- Vaginal hygiene
- Wound care per prescribed order
- Pain relief/comfort measures
- Skincare
- Vaginal hygiene
- Wound care procedure to patient/caregiver
- Skin care to prevent further degeneration from fecal/urinary incontinence
- Need to take/recall temp. and relationship to disease process
- Pressure relieving devices
- Measures to decrease pressure points and improve circulation
- Nutrition/Hydration and need for proper maintenance of diet in healing process
- Infection control measures relative to wound care
- Other (specify)

**Direct Care**

- Wound care
- Venipuncture
- Wound C & S

**Review/Revised By**

- (Signature/title/date)
- (Signature/title/date)
- (Signature/title/date)
### Nursing Diagnosis

- Fluid volume excess
- Tissue perfusion, altered
- Management of therapeutic regimen, ineffective
- Knowledge deficit (specify)
- Nutrition, altered
- Other (specify)

### Onset

**Endocrine Care Plan**

#### Nursing Diagnosis

- Pain
- Injury, high risk for
- Management of therapeutic regimen, ineffective
- Other (specify)
- Anxiety
- Communication, impaired verbal

### Onset

**Comfort/Pain Care Plan**

#### Nursing Diagnosis

- Pain
- Injury, high risk for
- Management of therapeutic regimen, ineffective
- Other (specify)
- Anxiety
- Communication, impaired verbal

### Onset

#### Desired Outcomes

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Target DATE</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluid volume excess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tissue perfusion, altered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of therapeutic regimen, ineffective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge deficit (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition, altered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Observations/Assessments

- Vital signs
- Safety needs
- Weight
- Mental status
- Nutritional status
- Fluids and electrolytes

#### Teach/Instruct

- Self/caregiver admin. of insulin, to include knowledge of purpose, dose, side effects and schedule
- Self observational skills (BG, weights, etc.)
- Action, side effects, dosage, schedule of oral hypoglycemics
- S/S, prevention, emergency treatment of hypo/hyperglycemia
- Self glucose monitoring
- Insulin mixing
- S/S of infection
- Urine testing
- Special diet:

#### Direct Care

- Admin. of insulin
- Venipuncture

#### Revised/Reviewed by

- Signature/title/date

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**COMFORT/PAIN CARE PLAN**

- Absence of pain or discomfort as evidenced by patient responses, appearance and increased functional mobility, where possible.
- Patient/caregiver will verbalize/demonstrate understanding of comfort measures.
- Therapeutic pharmacological levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient/caregiver prepares correct meals and verbalizes dietary instructions related to condition.
- Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.
- Other (specify)

### Revised/Reviewed by

- Signature/title/date

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**ENDOCRINE CARE PLAN**

- Patient/caregiver will verbalize understanding of diabetes disease process with S/S of complications and actions to take within 1 week.
- Patient/caregiver will demonstrate appropriate and safe insulin technique within 2 weeks.
- Patient/caregiver will verbalize and demonstrate understanding of diabetes self-care needs within 2 weeks.
- Patient will have no evidence of complications related to:__________
- Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient/caregiver prepares correct meals and verbalizes dietary instructions related to condition.
- Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.
- Other (specify)

### Revised/Reviewed by

- Signature/title/date

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**Pain**

- Absence of pain or discomfort as evidenced by patient responses, appearance and increased functional mobility, where possible.
- Patient/caregiver will verbalize/demonstrate understanding of comfort measures.
- Therapeutic pharmacological levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient will have no evidence of complications related to:__________
- Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient/caregiver prepares correct meals and verbalizes dietary instructions related to condition.
- Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.
- Other (specify)

### Revised/Reviewed by

- Signature/title/date

---

**Comfort/Pain**

- Absence of pain or discomfort as evidenced by patient responses, appearance and increased functional mobility, where possible.
- Patient/caregiver will verbalize/demonstrate understanding of comfort measures.
- Therapeutic pharmacological levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient will have no evidence of complications related to:__________
- Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient/caregiver prepares correct meals and verbalizes dietary instructions related to condition.
- Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.
- Other (specify)

### Revised/Reviewed by

- Signature/title/date

---

**ENDOCRINE/PAIN**

- Absence of pain or discomfort as evidenced by patient responses, appearance and increased functional mobility, where possible.
- Patient/caregiver will verbalize/demonstrate understanding of comfort measures.
- Therapeutic pharmacological levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient will have no evidence of complications related to:__________
- Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient.
- Patient/caregiver prepares correct meals and verbalizes dietary instructions related to condition.
- Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.
- Other (specify)
### Gastrointestinal Care Plan

**Nursing Diagnosis:**
- Diarrhea
- Nutrition, altered
- Fluid volume deficit
- Constipation
- Management of therapeutic regimen, ineffective
- Knowledge deficit (specify)
- Other (specify)

**Onset**

<table>
<thead>
<tr>
<th>Desired Outcomes</th>
<th>Target Date</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate nutritional and hydration intake evidenced by dietary compliance within 1 week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate knowledge of disease process as evidenced by patient responses to increased comfort within 1-2 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return to baseline bowel pattern as evidenced by regular bowel movements and increased comfort within 1-2 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimal fluid and electrolyte balance as evidenced by no S/S of dehydration and electrolyte levels WNL within 1 week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with new and/or revised bowel regimen as demonstrated by patient and/or caregiver verbalization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic pharmacologic levels achieved as demonstrated through venipuncture by range WNL for patient. Target range:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
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<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Teach/Instruct**

- Fluid intake needs
- New bowel regimen
- Nutritional needs
- S/S of impaction
- NG/GT feeding
- Suppository adm.
- Fruit/Fiber increase
- Ostomy care
- Bowel training
- Ileostomy: conduit care

**Direct Care**

- Thrush/Reinsert NG tube
- Perform rectal exam
- Enemas:
  - Size
  - Type
  - Frequency

**Observations/Assessments**

- Vital signs
- GI status
- Safety needs
- CG ability to care for patient
- Weight
- Self-care ability
- Mental status
- Medication response
- Nutritional status
- Fluids and electrolytes
- Other (specify)

**Teach/Instruct**

- Use of nutritional supplements
- Fluid requirements/restrictions
- Mgmt. of nausea/vomiting
- Mgmt. of constipation/diarrhea
- Use of bulk-forming agents
- NG feeding/GT feeding
- Admin. of solution
- Use of equipment
- Head elevation
- S/S complications

**Direct Care**

- Refer to MSW
- Suicide prevention protocol
- Refer to geriatric crisis/adult services
- Refer to local mental health/crisis
- Refer to psych nurse

---

**Coping/Emotional/Social Care Plan**

**Nursing Diagnosis:**
- Adjustment, impaired
- Anxiety
- Caregiver role strain, high risk for
- Coping, ineffective: individual/family
- Powerlessness
- Other (specify)

**Onset**

<table>
<thead>
<tr>
<th>Desired Outcomes</th>
<th>Target Date</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved coping behavior as evidenced by verbalization and ability to maintain within 1-2 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
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<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
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</tr>
</tbody>
</table>

**Teach/Instruct**

- Stress management skills
- Coping/Problem solving strategies

**Direct Care**

- Refer to MSW
- Suicide prevention protocol
- Refer to geriatric crisis/adult services
- Refer to local mental health/crisis
- Refer to psych nurse

---

**Review/Revised By**

- (Signature/title/date)
- (Signature/title/date)
- (Signature/title/date)
NURSING DIAGNOSIS:  ❑ Spiritual Disconnection/Distress
❑ Other (specify)  

ONSET [ ] / [ ] / [ ]  PLAN DEVELOPED BY (Signature/title/date)  

<table>
<thead>
<tr>
<th>DESIRED OUTCOMES</th>
<th>TARGET DATE</th>
<th>DATE ACHIEVED</th>
<th>SKILLED INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver will utilize available spiritual resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/Caregiver will achieve spiritual connection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OBSERVATIONS/ASSESSMENTS
❑ Spiritual Needs
❑ Patient Belief System
❑ Primary Caregiver Belief System
❑ Conflicts
❑ Self-expression
❑ Other

TEACH/INSTRUCT
❑ Resources Available
❑ Normal Anticipatory Grieving

DIRECT CARE
❑ Contact Patient’s Clergy
❑ Contact Primary Caregiver’s Clergy
❑ Refer for Ministerial Intervention
❑ Assist with Spiritual Practices
❑ Baptism
❑ Anointing with Oil
❑ Last Rites
❑ Assist with Funeral Planning/Memorial Services
❑ Other

OTHER (SPECIFY)