

Cabrillo College Associate Degree Nursing Program
Guidelines for Clinical Preparation and the Nursing Care Plan

The following guidelines have been developed to assist you in your preparation and organization as you provide care for your assigned Clients. It also will assist you in the development of individualized nursing plans of care while applying the nursing process within the framework of the Neuman Systems Model. The required written preparation (Preparation Sheets 1 & 2, Medication Sheet, Clinical Work Sheet, Client Assessment Applying the Neuman Model and Nursing Care Plan) is to be completed as directed on all assigned clients. The clinical preparation portion is to be completed prior to giving client care. Your clinical instructor will review your paperwork and provide feedback to you regarding your depth and breadth of preparation. In conjunction with observing your clinical performance, this paperwork gives your instructor insight into your developing knowledge base.

**Photocopying the client chart, medication record or Kardex is prohibited.
No paperwork with the client's name may be taken from the clinical setting.**

Clinical Preparation Sheet – Part 1

Patient ID: Client confidentiality must be strictly adhered to. Use only initials and include the room number below.

Student Name: Please place on every page.

Date of Care: Dates the student delivered care.

Pathophysiology: After researching the client's medical diagnosis, use nursing program textbooks, the internet, and other resources to research the pathophysiology of the medical diagnosis and if there is more than one how do they relate to each other. In this section describe the pathophysiology in your own words. This is not a definition of the disease. You may complete this section in narrative form with arrows indicating relationships between factors or by using a concept map indicating relationships. Focus on what is actually or potentially causing the client's clinical manifestations or there current "chief complaint."

Kardex Information:

Date of Admission: Date of current admission

Age: Age and gender in this section (Example: MM, 40 age range, Male)

Doctors: Primary care physician and any specialist on the case.

Allergies: Refers to documented allergies. These will be indicated on the front cover of the client's record and on the MAR (Medication Administration Record) and may include medications, food, tape, etc.

Diet: Indicate the client's current diet orders in this section.

Activity Order: This information is found on the Kardex.

Code Status: Refers to whether the client wishes to be resuscitated in the event of a cardio respiratory arrest. This will be found in several places on the chart and will be indicated on the Kardex.

Lab ordered: Lab ordered for your dates of care.

IV type and site: The type of IV access and location. Example: peripheral Rt. hand

IV Solution and Rate: Indicate the client's IV orders in this section (found on the MAR) and D5/W.45 NS, 125 ml/hr.

Chief Complaint: Indicate the reason the client is in the hospital – the C/C is usually described in the client’s own words with 1-2 symptoms and duration. (Example: “Chest pain for 3 hours”). This can be found on the Emergency room record, the nursing admission form, or the History and Physical.

Admitting Diagnosis The admitting medical diagnosis is found at the end of the client’s history and physical or on the Kardex. Include the date of admission. Please list pertinent medical diagnoses that can be found on the history and physical or the progress notes in the client’s chart. Each semester you will be increasingly responsible for integrating the diagnoses.

Semester 1-First 2 diagnoses

Semester 2-First 3 diagnoses

Semester 3 & 4: All diagnoses

Date and Type of Surgery: Indicate any surgical procedures performed during current hospital admission. This will be indicated with the date performed on the client’s Kardex. (Example:

Appendectomy 9/23/01).

Past Medical History (PMH): If the client has pre-existing medical diagnoses that will be complicated by the current diagnosis or will complicate the client’s recovery from the current condition, list it in this section. (Example: Diabetes Mellitus for a surgical client or Congestive Heart Failure for a client requiring intensive physical therapy).

Other Disciplines: List other disciplines involved in the care of the client (i.e.: respiratory therapy, discharge planning, social services etc.).

Significant Abnormal Lab Values: Your textbook and lab/diagnostic book will be helpful to answer the questions regarding causes of abnormal values and treatment. What intervention is being done relative to the abnormal lab?

Diagnostic Procedures: List the procedures such as radiology, biopsies, etc. Why was it done? What type of preparation or post-procedure monitoring is required? What were the results of the tests?

Tubes, Line Drains or Treatments: Why is your client receiving a specific intervention and what is the focused nursing assessment regarding this intervention and what is the standard for documentation of this intervention?

Clinical Preparation Sheet – Part 2

I am going to pay special attention to: Based on your prep (reading the chart, use of textbooks, etc.), what do you anticipate is the client’s priority issue?

What teaching will my client require? Do you need to review diabetic teaching? Some possible resources are listed on the form.

Time Management: This section is for you to begin to organize yourself during your clinical shift. Write in the times and the nursing care you will provide. This is the area to track tasks and to-do items so that as priorities change you can move them as needed.

Quick Assessment: Brief assessment of your client to identify critical problems early. A full page explanation is at the end of these guidelines.

End of Shift ✓ list: This is a helpful reminder so you don’t omit any important duties.

Notes/To Do List/Questions/skills to review/words to look up: A place for you to keep track of items that come up during the shift, reminders of areas you need to review in preparation for performing skills and words to add to a new vocabulary. **Resources used for prep:** Another memory-jogger to remind you of all the resources available to you.

Post-Clinical Self-Evaluation: This is a place for you to reflect on the day's challenges and successes. What will you do in the future to grow from your experiences?

The Medication Work Sheet

Using the medication administration record (MAR); list all of the client's medications and the data requested for each one. Use your pharmacology text or clinical drug handbook to research the significant data about each drug.

Classification: Drugs are classified in several ways, according to mechanism of action, or even legal status. Drug classification in this section is based on family groups of drugs that have similar actions such as calcium channel blockers, anti-hypertensive, anti-infective, hormones, opiates etc...

Drug, Generic/Trade: List the generic name of the drug and include the trade (brand) name of the drug as appropriate.

Dose and Frequency: give the dosage and frequency of administration in 24 hrs. Example: 2 grams twice per day, 300 mg daily.

Route: method of administration i.e.: PO, IM, IV, SQ, topical, PR, via inhalation.

Reason Patient Taking: Correlate with their admitting diagnosis or a diagnosis found in the past medical history. Why is this client receiving that drug?

Nursing Considerations/Side effects/ Hold For/ Critical Labs: If there are significant parameters for the drug; indicate it in this section of the Medication Work Sheet. Also indicate the assessment data that indicates that the drug should be held and other nursing actions that are indicated. Example: "Hold for BP < 100 systolic... notify MD"; should be taken with food.

Evaluation of Patient Response: To be completed during the clinical shift. For example, if a client received an antihypertensive medication, was the blood pressure controlled? When you administered the medication did you instruct the client about how to reduce the risk of orthostatic hypotension?

If possible find out from the MAR or the Pyxis how the medication is supplied so calculations can be done before clinical. Use the back of the sheet to write the formula or work the calculation. If IV piggybacks are to be given, investigate the drop factor of the tubing and do your calculations for rate before clinical.

The Clinical Work Sheet

The clinical worksheet is designed to gather data utilizing the Neuman Systems Model to organize data within a systematic framework.

The Neuman variables are listed in bold with discreet areas of focus under each variable to assist you with doing a comprehensive assessment. **Not all possible aspects of the client' assessment is represented here and you may need to expand or add individualized data as appropriate to your client.** As you progress in the program you should integrate knowledge gained from theory classes, skills lab, and clinical to expand the depth of your assessment reflected in this form. Your clinical instructors will assist you regarding semester-appropriate expectations for depth of assessment. For example, first semester students complete a less in-depth assessment one time during the shift. Second through fourth semester students are expected to perform increasingly detailed and focused assessments at beginning- and mid-shift.

HT/Wt (Height /Weight) record height and weight here.

Intake and Output: Use this section to record I&Os during the shift. This data will then need to be reported to your nurse and/or recorded in the client record.

Last BM: record the date of the client's last bowel movement.

Dressings and Wound Care: Record the time and observations for any wound care provided.

Fingerstick blood glucose and Insulin administration: Record values and dosages in this section.

Other treatment: For example: change colostomy bag, range of motion rt. arm.

Safety Issues: Indicate what type of restraint is being used on the client, what fall precautions are being used, other concerns including hard-of-hearing, visual loss that may effect safety and care plan.

Vital signs: Document any vital signs taken during the shift.

Today's lab results: Record the lab results taken on the day of care. Indicate whether they are normal or abnormal and consider the significance of the result.

Client Assessment-Applying the Neuman Systems Model A&B

The 'Client Assessment-Applying the Neuman Systems Model' form comes in two formats. Each format contains the same content. The formats offer two styles of approaching the application of the Neuman Systems Model to your client assessment. You will be required to complete **only one** form, A or B.

Form A: Write assessment data in each variable and show the level of arrow penetration into the lines of defense. Indicate whether a variable is a resource or a stressor as you draw your arrow. The depth of penetration of your arrow should reflect the depth of penetration of the lines of defense or resistance. For example, if your client has symptoms present then your line should have penetrated the normal line of defense. If your client is in a life-threatening situation then the arrow should approach the core. Associate your arrows and assessment data with the five variables.

Form B: Write assessment data in each variable and state the level of arrow penetration into the lines of defense. Indicate whether a variable is a resource or a stressor. The 5 variables are listed on the left side of the page and you may place assessment data in this area to assist with organizing your data to identify possible stressors and lines of defense or resistance. From assessment data determine in what category it belongs. Note in your categories level of penetration of the lines of defense and resistance toward the core.

For definitions of Neuman Systems Model terms see your student handbook and theory content covering this material.

The Nursing Care Plan

The nursing care plans are offered in two formats: a six-column care plan and a five-column care plan. They are the same in content. The care plan format you use will be at your instructor's discretion. Level one care plan is in the six-column format below. Section I of your Nursing Diagnosis Handbook also explains the steps to writing a care plan, and is an excellent reference.

Cluster Data: From the 'client assessment' and 'application of the Neuman Model' assessment pages, bring forward relevant data under each variable that clusters to form the description of a discreet client problem. Utilize as evidence: the stressors, indicators of the level of penetration into the lines of defense, and the symptoms generated by the lines of resistance to define the cluster. Whenever possible, there must be 3 items of supporting data in the cluster to support the nursing diagnosis. These supporting data are listed as "defining characteristics" under each nursing diagnosis in your Nursing Diagnosis Handbook. Please note: the terms cluster data, defining characteristics, clinical manifestation, signs and symptoms generally relate to the same phenomena.

Nursing Diagnosis:

The nursing diagnosis is a statement that defines a client health problem that is an actual or potential that the registered nurse is licensed and competent to treat. Select the 3 most important Nursing diagnoses from the current NANDA list. Prioritize the selected nursing diagnoses according to the client's current

needs, considering: actual or potential risk for stressors. Develop only one nursing diagnosis per care plan page.

The related to clause: Include with the nursing diagnosis the etiology – the “related to” clause. The etiology needs to relate to the actual problem not the medical diagnosis, and is something that nurses can influence. An example is: Anxiety (the nursing diagnosis) related to lack of understanding about health status.

1. **Main** – The most immediate cause of the clinical manifestation cluster which requires a response by the client. **There can be only one cause identified as main.** The main cause will become the “related to” statement in the Nursing Diagnosis.
2. **Contributing** – Responses present in the situation that influence or contribute to the clinical manifestations triggered by the main cause.
3. **Possible** – Environmental factors whose effects in the current situation are unclear. These include the intuitions, educated guesses, “hunches” of the nurses based on knowledge and experience that have not yet been validated. Once they become validated, they become either main or contributing causes.
4. Label the causes listed as (M) main, (C) contributing or (P) possible.

Goals/Expected Outcomes

State the desired client responses/client outcomes, which are measurable with a given time frame.

Example 1: “The client will ambulate to nurse’s station with one person assist 3 times during shift.”

Example 2: “The client will perform activities of recovery with reported acceptable level of pain 2-3/10 by the end of the shift. Goals and outcomes may include the client and family and are individualized according to their needs and desires. Select two short term outcomes and one long term outcome in this area. Identify the criteria for outcome achievement in the goal statement. How will you know when the client outcome is met?”

Nursing Interventions

List at least three nursing interventions to assist the client to meet their outcomes.

The primary target for interventions is the “related to” clause. Secondary target is modification of contributing causes. Possible causes require communication and further assessment for validation. Once validated, possible causes become main or contributing and require specific interventions. Select/plan 3 interventions for each diagnosis that:

- are directly related to the short term goals
- will modify the variables/causes that support resistance or reconstitution
- are individualized and realistic for client and environment
- are written with specific parameters
- are not repeated among different diagnoses
- are independent or interdependent nursing actions

Scientific Rationale

The Scientific rationale is a statement identifying the scientific basis for each specific intervention. It answers the questions, “how?” and “why?” the interventions will work to support the intended outcome. Consult resources for theory related to stated nursing diagnoses and intervention, and synthesize in your own words the most appropriate concepts that apply to the intervention.

Evaluate Outcomes

Assess the client’s response to nursing interventions and determine if the outcomes are met or unmet. (Note: you are evaluating the patient outcomes, not if you did or did not do the intervention). List the supporting assessment data for each decision determine if interventions should be continued or revised. Briefly state needed revision of outcomes or interventions.

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