Nursing care plane

Nurse name Date

Client name Age

Assessment	Nursing Diagnosis	Diagnosis	orders	Rataoinale	Implementions	Evaluation

Nursing care plane

Nursing Diagnosis

Date	Nursing Outcomes	Nursing Interventions	Evaluation

Nursing care plane

Student……Patient Identifier Code……..Date…….

Nursing Diagnosis

Assessment	Expected Outcomes	Interventions	Rataoinale	Evaluation

Nursing Care Plan

CLIENT ID:
NAME:
D.O.B.:
DOCTOR:
PENSION:

RESIDENT'S: .....

CARE ALERT: FALLS RISK ☐ WANDERS ☐ BLIND ☐ DEAF ☐ CONFUSE

Diagnosis: .....

LIFESTYLE SUPPORT NEEDS	*GOAL OF CARE*	*CARE OR INTERVENTION REQUIRED* *Tick and/or Highlight Appropriate Response*
MEDICATION ADMINISTRATION Baseline Health Assessment *Self Administration Medication Management (11-03)* *Medication Assessment (11-59)*	**RESIDENT MEDICATIONS ARE MANAGED SAFELY & CORRECTLY**	Level of Assistance required: ☐ Extensive prompting ☐ Standing by to observe ☐ Self administers medication ☐ Staff administers medication ☐ Refer to medication chart for specific instructions ☐ Other
Notes		
PAIN MANAGEMENT *Elderly Mobility Scale (11-12)* *Self Administration Medication Management (11-03)* *Specific Needs Management Plan (11-22a)*	**RESIDENT IS AS FREE AS POSSIBLE FROM PAIN**	☐ Reposition ☐ Massage ☐ Analgesia ☐ Heat packs ☐ Aromatherapy ☐ Relaxation Tapes ☐ Supportive device eg. ..... ☐ One to one support/Diversion ☐ Other ..... ☐ Refer to pain management program
Notes		
COMMUNICATION **Links to Assessments:** Baseline Health *Assessment* *Communication Assessment (11-04)*	**RESIDENTS OPTIMAL LEVELS OF COMMUNICATION ARE MAINTAINED**	***VISION*** Glasses ☐Yes ☐No Wears always ☐Yes ☐No Reading only ☐Yes ☐No Magnifier ☐Yes ☐No Needs assistance with glasses ☐Yes ☐No Refer to special nursing care needs ☐Yes ☐No ***SPEECH*** Difficulty with expressive communication ☐Yes ☐No Difficulty with receptive communication ☐Yes ☐No Is English the first language? ☐Yes ☐No If no, specify: ..... Non-verbal aids used ☐Yes ☐No Need help with communication aids ☐Yes ☐No Other .....

Name	***Date***
Signature	***Designation***

Nursing Care Plan

CLIENT ID:
NAME:
D.O.B.:
DOCTOR:
PERSION:

LIFESTYLE SUPPORT NEEDS	*GOAL OF CARE*	*CARE OR INTERVENTION REQUIRED* *Tick and/or Highlight Appropriate Response*
Links to Assessments: *Eating & Assessment (11-09a)* *Nutrition Assessments for Residents at Risk (11-41)* Dietician Assessment Speech Therapist Assessment	**RESIDENTS NUTRITION &HYDRATION IS MAINTAINED AT OPTIMUM LEVEL**	**Preferences** Size of meals: ☐ small ☐ medium ☐ large Likes:..... Dislikes:..... Preferred drinks: Tea ☐ Coffee ☐ Milk ☐ Other ☐ **Preferred eating arrangements** ☐ Breakfast in dining room/sitting room/own room ☐ Lunch in dining room/sitting room/own room ☐ Evening meal in dining room/sitting room/own room **Diet** ☐ Normal ☐ Modified ☐ Specify..... ☐ Supplements: Type: ..... Amount: .....Frequency..... **Dysphagia management** Difficulty with chewing ☐Yes ☐No Difficulty with swallowing ☐Yes ☐No Thickened fluids ☐ full thick ☐ 1/2 thick ☐ 1/4 thick **Enteral feeding** PEG feeds (type): ..... If PEG, ☐ Bolus ☐ Continuous **Assistance required:** ☐ Cut up food ☐ Butter bread & apply spreads ☐ Leave glass of fluid within reach (type): ..... ☐ Place utensils in residents hand ☐ Special utensils required ☐ Refill fluids at each attention ☐ Guide food into residents mouth ☐ Encourage finger food ☐ Place food into residents mouth ☐ Supervise eating/drinking ☐ Entire meal ☐ Part of meal ☐ Encourage to remain at table ☐ Weigh-frequency ☐ Other .....
Name		***Designation***
Signature		***Date***
Notes		