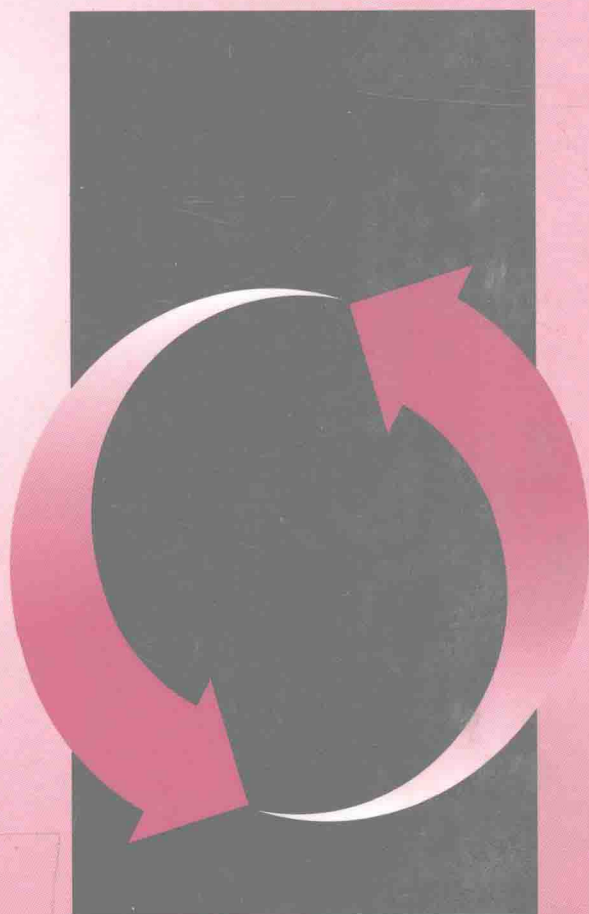


# **NURSING CARE PLANS**

**Nurses'  
#1 Choice for  
Planning  
Patient  
Care**

**Guidelines for Planning  
and Documenting  
Patient Care**

**Edition 3**



**Marilynn E. Doenges  
Mary Frances Moorhouse  
Alice C. Geissler**

# **NURSING CARE PLANS**

## **Guidelines for Planning and Documenting Patient Care Edition 3**

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To our spouses, children, parents, and friends, who much of the time have had to manage without us while we work as well as cope with our struggles and frustrations.

The Doenges families: Dean, Jim, Barbara, and Bob Lanza; David, Monita, Matthew, and Tyler; John, Holly Sponaugle, Nicole, and Kelsey; and the Daigle family, Nancy, Jim, Jennifer, and Jonathan.

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To our FAD family, especially Bob Martone, Ruth De George, Herb Powell, and Crystal McNichol, whose support is so vital to the completion of a project of this magnitude.

To the nurses we are writing for, who daily face the challenge of caring for the acutely ill patient and are looking for a practical way to organize and document this care. We believe that nursing diagnosis and these guides will help.

Finally, to the late Mary Lisk Jeffries, who initiated the original project. The memory of our early friendship and struggles remains with us. We miss her and wish she were here to see the growth of the profession and how nursing diagnosis has contributed to the process.



# PREFACE

One of the most significant achievements in the health care field during the past 20 years has been the emergence of the nurse as an active coordinator and initiator of patient care. While the transition from help-mate to health care professional has been painfully slow and is not yet complete, the importance of the nurse within the system can no longer be denied or ignored. Today's nurse designs nursing care interventions that will move the total patient toward the goal of improved health.

The current state of the theory of Nursing Process, Diagnosis, and Intervention has been brought to the clinical setting to be implemented by the nurse. This book gives definition and direction to the development and use of individualized nursing care. The book is not an end in itself therefore, but it is a beginning for the future growth and development of the profession.

Professional care standards, physicians, and patients will continue to increase expectations for nurses' performance as each day brings advances in the struggle to understand the mysteries of normal body function and human response to actual and potential health problems. With this increased knowledge comes greater responsibility for the nurse. To meet these challenges competently, the nurse must have up-to-date physical assessment skills and a working knowledge of pathophysiologic concepts concerning the more common diseases/conditions presented on a general medical/surgical unit. This book is a tool, a means of attaining that competency.

In the past, plans of care were viewed principally as learning tools for students and seemed to have little relevance after graduation. However, the need for a written format to communicate and document individualized patient care has been recognized in all care settings. In addition, governmental regulations and third-party payor requirements have created the need to validate the appropriateness of the care provided, as well as the need to justify patient care charges and staffing patterns. Thus, although the student's "case studies" were too cumbersome to be practical in the clinical setting, the patient plan of care meets the aforementioned identified needs. The practicing nurse, as well as the nursing student, will welcome this text as a ready reference in clinical practice. The book is designed for use in the acute medical/surgical setting and is organized by systems for easy reference. Rationales (which state not only why an intervention is important but also provide a brief related pathophysiology, when applicable) enhance the reader's understanding of the intervention. This information also serves as a catalyst for thought in planning and evaluating the care being rendered.

Chapter 1 discusses some current issues and trends affecting the nursing profession. An overview of cultural, community, sociologic, and ethical concepts impacting on the nurse is included. The important concept of cooperation and coordination with other health care professionals is integrated throughout the plans of care.

Chapter 2 reviews the historic use of the nursing process in formulating plans of care and the nurse's role in the delivery of that care. Nursing diagnosis is discussed to assist the nurse in understanding its role in the nursing process.

Chapter 3 discusses construction of the plan of care and the use and adaptation of the guides for planning care presented in this book. A nursing-based assessment tool is presented to aide the nurse to

make the transition from theory to practice. Finally, a sample patient situation with data base and corresponding plan of care are included.

Chapters 4 through 17 present guides for planning care that include information from multiple disciplines to assist the nurse to provide holistic care. Each plan of care is developed by identifying nursing diagnoses with "related to" and "evidenced by" factors that provide an explanation of patient problems/needs. Each plan includes a patient assessment data base (presented in a nursing format) and associated diagnostic studies. After the data base is collected, nursing priorities are sifted from the information to help focus and structure the patient care provided. Discharge goals are also listed to identify which general goals should be accomplished by the time of discharge from acute care. In addition, mean length of stay has been identified to provide a general idea of time constraints for achieving discharge goals. Desired patient outcomes are stated in behavioral terms that can be measured to evaluate the patient's progress and the effectiveness of care provided. The interventions are designed to assist with problem resolution. Rationales for these actions are provided to enable the nurse to decide whether the intervention applies to a particular patient situation. Additional information is provided to assist the nurse in identifying and planning for rehabilitation as the patient progresses toward discharge.

As a final note, this book is not intended to be a procedure manual, and efforts have been made to avoid detailed descriptions of techniques/protocols that might be viewed as individual/regional in nature. Instead, the reader is referred to a procedure manual/standards of care book for in-depth direction for these concerns.

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Thought processes, altered	377
Sensory-perceptual alteration: (specify)	380
Sleep pattern disturbance	381
Self-care deficit: (specify)	382
Nutrition, altered: less/more than body requirements, high risk for	384
Constipation/incontinence, (specify) and/or urinary elimination, altered patterns	385
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Home maintenance management, impaired/health maintenance, altered	389
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Physical mobility, impaired	394
Self-care deficit: (specify)	396
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Powerlessness [specify degree]/hopelessness	399
Coping, individual ineffective, high risk for	400
Family coping, ineffective: compromised/disabling	402
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## **7 OPTHALMOLOGIC 408**

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Infection, high risk for	411
Sensory-perceptual alteration: visual	412
Knowledge deficit [learning need], regarding condition, prognosis, treatment	413
GLAUCOMA	415
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Anxiety [specify level]	416
Knowledge deficit [learning need], regarding condition, prognosis, and treatment	417

## **8 GASTROENTEROLOGY 420**

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Nutrition, altered: less than body requirements	423
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