# Patient Information

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| Patient Name: |  |

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| Date Of Birth: |  | Age: |  | Gender: |  |

## Medical History

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## Allergies

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## Medications

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# Care Plan #1

Assessment: *Gather subjective data (patient reports) and objective data (clinical observations, lab results, vital signs).*

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| A 65-year-old male patient recovering from abdominal surgery reports pain at the incision site, rated 7/10 on the pain scale. |

Diagnosis: *Formulate nursing diagnoses based on patient assessment. Use* [*NANDA*](http://www.nandanursingdiagnosislist.org/) *guidelines for accurate terminology. Include* ***problem and its definition, etiology, & risk factors/defining characteristics****.*

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| Acute pain related to surgical incision as evidenced by patient’s verbal report of pain and guarding behavior. |

Outcomes: *Define specific, measurable goals for patient recovery. Include both short-term and long-term objectives.*

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| 1. Patient will report a reduction in pain to 3/10 or less within 24 hours. 2. Patient will demonstrate use of non-pharmacological pain relief techniques by the end of the shift. |

Interventions: *List planned nursing actions to address the diagnosis and achieve outcomes. Include patient responses and treatment details.*

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| 1. Administer prescribed analgesics (e.g., morphine or acetaminophen) as ordered and monitor for side effects. 2. Teach the patient deep breathing and relaxation techniques to help manage pain. 3. Apply a cold pack to the incision site as ordered to reduce swelling and pain. 4. Reposition the patient comfortably to reduce strain on the incision site. 5. Assess pain level every 2 hours using a pain scale and document findings. |

Evaluation: *Assess the patient’s progress towards the outcomes. Determine if the plan should be continued, adjusted, or terminated based on the patient’s response.*

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| 1. Patient reports pain level decreased to 3/10 within 24 hours. 2. Patient demonstrates proper use of relaxation techniques. |

# Care Plan #2

Assessment: *Gather subjective data (patient reports) and objective data (clinical observations, lab results, vital signs).*

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| An 80-year-old female patient with a history of osteoporosis and unsteady gait is admitted to the hospital for dehydration. |

Diagnosis: *Formulate nursing diagnoses based on patient assessment. Use* [*NANDA*](http://www.nandanursingdiagnosislist.org/) *guidelines for accurate terminology. Include* ***problem and its definition, etiology, & risk factors/defining characteristics****.*

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| Risk for falls related to unsteady gait and generalized weakness. |

Outcomes: *Define specific, measurable goals for patient recovery. Include both short-term and long-term objectives.*

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| 1. Patient will remain free from falls during hospitalization. 2. Patient will use assistive devices (e.g., walker) correctly by discharge. |

Interventions: *List planned nursing actions to address the diagnosis and achieve outcomes. Include patient responses and treatment details.*

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| 1. Keep the bed in the lowest position and ensure call light is within reach. 2. Provide nonslip footwear and ensure the environment is free of clutter. 3. Assist the patient with ambulation and encourage the use of a walker. 4. Educate the patient and family about fall prevention strategies. 5. Monitor the patient’s gait and strength during each shift. |

Evaluation: *Assess the patient’s progress towards the outcomes. Determine if the plan should be continued, adjusted, or terminated based on the patient’s response.*

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| 1. Patient does not experience any falls during hospitalization. 2. Patient demonstrates proper use of a walker by discharge. |

# Care Plan #3

Assessment: *Gather subjective data (patient reports) and objective data (clinical observations, lab results, vital signs).*

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| A 70-year-old male patient with chronic obstructive pulmonary disease (COPD) presents with shortness of breath, oxygen saturation of 88%, and use of accessory muscles for breathing. |

Diagnosis: *Formulate nursing diagnoses based on patient assessment. Use* [*NANDA*](http://www.nandanursingdiagnosislist.org/) *guidelines for accurate terminology. Include* ***problem and its definition, etiology, & risk factors/defining characteristics****.*

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| Impaired gas exchange related to alveolar-capillary membrane changes as evidenced by low oxygen saturation and dyspnea. |

Outcomes: *Define specific, measurable goals for patient recovery. Include both short-term and long-term objectives.*

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| 1. Patient will maintain oxygen saturation above 92% within 2 hours. 2. Patient will demonstrate improved breathing patterns by the end of the shift. |

Interventions: *List planned nursing actions to address the diagnosis and achieve outcomes. Include patient responses and treatment details.*

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| 1. Administer supplemental oxygen as prescribed and monitor oxygen saturation continuously. 2. Position the patient in high Fowler’s position to promote lung expansion. 3. Teach the patient pursued-lip breathing techniques to improve oxygenation. 4. Monitor respiratory rate, depth, and effort every 30 minutes. 5. Encourage fluid intake to thin secretions, unless contraindicated. |

Evaluation: *Assess the patient’s progress towards the outcomes. Determine if the plan should be continued, adjusted, or terminated based on the patient’s response.*

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| 1. Patient’s oxygen saturation improves to 94% within 2 hours. 2. Patient demonstrates effective pursed-lip breathing technique. |