

Nursing care plan

What is a nursing care plan?

is a formal process that includes correctly identifying existing needs, as well as recognizing potential needs or risks.

Objectives:

- Promote evidence-based nursing care and to render pleasant and familiar conditions in hospitals or health centers.
- Support holistic care which involves the whole person including physical, psychological, social and spiritual in relation to management and prevention of the disease.
- Establish programs such as care pathways and care bundles. Care pathways involve a team effort in order to come to a consensus with regards to standards of care and expected outcomes while care bundles are related to best practice with regards to care given for a specific disease.
- Identify and distinguish goals and expected outcome.
- Review communication and documentation of the care plan.
- Measure nursing care.

Types of Nursing Care Plans?

- 1- **Informal nursing care plan:** is a strategy of action that exists in the nurse's mind.
- 2- **A formal nursing care plan:** is a written or computerized guide that organizes information about the client's care.
 - Standardized care plans specify the nursing care for groups of clients with everyday needs.
 - Individualized care plans are tailored to meet the unique needs of a specific client or needs that are not addressed by the standardized care plan.

Components:

A nursing care plan (NCP) usually includes **nursing diagnoses**, client problems, expected outcomes, and nursing interventions and rationales. These components are elaborated below:

- 1- **Client health assessment:** medical results, and diagnostic reports. This is the first measure in order to be able to design a care plan. In particular, client assessment is related to the following areas and abilities: physical, emotional, sexual, psychosocial, cultural, spiritual/transpersonal, cognitive, functional, age-related, economic and environmental. Information in this area can be subjective and objective.
- 2- **Expected client outcomes:** are outlined. These may be long and short term.
- 3- **Nursing interventions:**
- 4- **Rationales:** for interventions in order to be evidence-based care.
- 5- **Evaluation:** This documents the outcome of nursing interventions.

Care Plan Formats

Assessment	Diagnosis	Outcomes	Interventions	Evaluation	Documentation
1- Client's history 2- Physical assessment 3- Psychological assessment 4- Social assessment 5- Spiritual assessment 6- Functional assessment 7- Environmental assessment 8- Cultural assessment 9- Age-related assessment 10- Economic assessment	1- Nursing diagnosis 2- Client's problem 3- Client's need 4- Client's goal 5- Client's outcome 6- Client's plan 7- Client's intervention 8- Client's evaluation 9- Client's documentation 10- Client's communication	1- Client's outcome 2- Client's goal 3- Client's need 4- Client's plan 5- Client's intervention 6- Client's evaluation 7- Client's documentation 8- Client's communication 9- Client's outcome 10- Client's goal	1- Client's intervention 2- Client's goal 3- Client's need 4- Client's plan 5- Client's intervention 6- Client's evaluation 7- Client's documentation 8- Client's communication 9- Client's outcome 10- Client's goal	1- Client's outcome 2- Client's goal 3- Client's need 4- Client's plan 5- Client's intervention 6- Client's evaluation 7- Client's documentation 8- Client's communication 9- Client's outcome 10- Client's goal	1- Client's documentation 2- Client's communication 3- Client's outcome 4- Client's goal 5- Client's need 6- Client's plan 7- Client's intervention 8- Client's evaluation 9- Client's documentation 10- Client's communication

Nursing Care

Jianjun Gao



Nursing Care:

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Table of Contents Nursing Care

1. Understanding the eBook Nursing Care
 - The Rise of Digital Reading Nursing Care
 - Advantages of eBooks Over Traditional Books
2. Identifying Nursing Care
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Nursing Care
 - User-Friendly Interface
4. Exploring eBook Recommendations from Nursing Care
 - Personalized Recommendations
 - Nursing Care User Reviews and Ratings
 - Nursing Care and Bestseller Lists
5. Accessing Nursing Care Free and Paid eBooks
 - Nursing Care Public Domain eBooks
 - Nursing Care eBook Subscription Services
 - Nursing Care Budget-Friendly Options
6. Navigating Nursing Care eBook Formats

- ePub, PDF, MOBI, and More
- Nursing Care Compatibility with Devices
- Nursing Care Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Nursing Care
 - Highlighting and Note-Taking Nursing Care
 - Interactive Elements Nursing Care
- 8. Staying Engaged with Nursing Care
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Nursing Care
- 9. Balancing eBooks and Physical Books Nursing Care
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Nursing Care
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Nursing Care
 - Setting Reading Goals Nursing Care
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Nursing Care
 - Fact-Checking eBook Content of Nursing Care
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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