CHAPTER 4

The Planning Step:
Creating the Plan of Care
STUDENT LEARNING OUTCOMES:

1. Names the expected outcomes of the planning step.
2. Identifies the importance of the plan of care.
3. Discusses how priorities are determined using Maslow’s hierarchy of needs.
4. Identifies how goals are determined for the individual client.
5. Explains why desired outcomes need to be measurable.
6. Lists five ways outcomes can be assured to be measurable.
7. Summarizes how nursing interventions are chosen for the individual client.
Application of the Nursing Process Through the Planning Step

Step I: Assessment

On 6/11/12 at 5:30 p.m., Michelle, a 14-year-old female (DOB 3/2/98), is admitted with compound multiple fractures of the right tibia and fibula and a mild concussion following a mountain-bike accident.

Assessment Data: Pain/Discomfort
**Application of the Nursing Process Through the Planning Step**

**Assessment Data**: Pain/Discomfort

**Subjective**
Location: Rt lower leg, as well as general muscle ache, multiple skin abrasions, and right-sided headache.
Intensity (0-10): 9/10
Frequency: Since accident
Quality: Sharp stabbing and aching Rt leg (headache dull, throbs)
Duration: Constant
Radiation: Toes to knee
Precipitating factors: Movement
How relieved: Morphine sulfate in ED
Associated symptoms: Muscle spasm

**Objective**
Facial grimacing: Yes
Guarding affected area: Yes
Emotional response: Tearful
Narrowed focus: Yes
Application of the Nursing Process Through the Planning Step

Step II: Need Identification

Based on this assessment (and additional data recorded in other sections of the Assessment Tool), using the diagnostic reasoning process and working with Appendix I, you choose the nursing diagnosis label acute Pain and write the plan of care.

6/11/12, 6 p.m.

Client Diagnostic Statement:

acute Pain related to movement of bone fragments Rt lower leg, soft tissue injury/edema, and use of external fixator as evidenced by verbal reports, guarding, muscle tension, narrowed focus, and tachycardia.
Application of the Nursing Process Through the Planning Step

Step III: Planning

Goal: Pain-free or controlled

Outcomes:
Client will:

• Verbalize relief of pain within 5 minutes of IV bolus/45 minutes of PO administration of medication
• Use relaxation skill to reduce level of pain by 6/12, 9 a.m.
• Identify methods that provide relief by 6/12, 4 p.m.
Application of the Nursing Process Through the Planning Step

Step III: Planning

Interventions:

• Maintain limb rest of Rt leg X 24 hour (6/12, 6 p.m.)
• Elevate lower leg with folded blanket
• Apply ice to area 20 minutes on/20 minutes off, as tolerated X 48 hours (6/13, 6 p.m.)
• Place cradle over foot of bed
• Document reports and characteristic of pain
• Medicate with morphine sulfate-PCA and bolus per peds protocol, advance to Vicodin 5 mg PO q4h, pm.
Application of the Nursing Process Through the Planning Step

Step III: Planning

Interventions: (continued)

• Demonstrate/encourage use of progressive relaxation techniques, deep-breathing exercises, and visualization.

• Provide alternate comfort measures, position change, backrub.
The documentation of the planning process is provided in the client's plan of care, which some nurses refer to as the "care plan."

**This plan of care is written to:**

- *Provide continuity of care* from nurse to nurse, from one nursing shift to the next, or from one unit/care setting to another.

- *Enhance communication*, as the written plan becomes a permanent part of the client record and supplies consistent information for each person who reads it.
THE CLIENT PLAN OF CARE

- Assist with determination of agency or unit staffing needs as well a setting of priorities for the work schedule and individual client assignments.

- Document the nursing process by providing reminder of what needs to be charted and when evaluations should be done.

- Serve as a teaching tool by haring nurses' expertise and fostering professional growth as nurses learn what interventions are successful.

- Coordinate provision of care among disciplines, maximizing effort and use of resource to enhance quality of care and client outcomes.
Healthcare includes many professional disciplines, each of which has its own definite characteristics and independent, but overlapping, functions.

The nurse is responsible for ensuring that all the different activities are coordinated.

This is essential to delivery of holistic, cost-effective healthcare.
DISCHARGE PLANNING

- Begins when the client enters the healthcare setting

- Nurse is responsible for planning continuity of care
  - between nursing personnel
  - between services within the care setting
  - between the care setting and the community
The format for documenting the plan of care is determined by agency policy.

Student plans of care (case studies) are developed individually and are very detailed.

Practicing professionals might use a computer with a plan of care database, standardized care plan form, or CLINICAL PATHWAYS (e.g., critical pathway, care map).

The plan of care must reflect the basic nursing standards of care; personal client data, non-routine care, and qualifiers such as time or amount are added, as appropriate.
- **Clinical pathways:**
  A type of abbreviated plan of care providing outcome-based guidelines for goal achievement within a designated length of stay

- **Concept/Mind mapping:**
  A care-planning technique using a graphic representation to visualize the interconnections among all the components of client care
FOR EXAMPLE:

Measure intake and output [insert frequency]

Increase oral fluids [insert amount and frequency]

Medicate with [insert name of medication, do e, and frequency] for [insert reason]

Weigh with bed scale [insert time, frequency, desired attire for consistency]
The plan of care enables visualization of the nursing process. A such, it is preserved as part of the client's permanent record. Therefore, all entries need to be dated and initialed or signed. Key words should be used instead of complete sentences, and only agency-approved abbreviations/symbol should be included (see end pages).

**FOR EXAMPLE:**

- 8/15 Routine urinary catheter care q (every) shift. RE
- 9/2 NPO (nothing by mouth) after 6 a.m., 9/3. PR
- 3/7 Maintain subarachnoid bolt per protocol. MT
Before the plan of care is implemented, it should be reviewed to ensure that:

- It is based on accepted nursing practice, reflecting knowledge of scientific principles, nursing standards of care, and agency policies.
- It provides for the safety of the client by ensuring that the care provided will do no harm.
- The client diagnostic statement are supported by the client data.
- The goals and outcomes are measurable/observable and can be achieved.
- The interventions can benefit the client/family/ significant other in a predictable way in achieving the identified outcome and that they are arranged in a logical sequence.
- It demonstrates individualized client care by reflecting the concerns of the client and significant others as well as their physical, psychosocial, and cultural needs and capabilities.
Professional concerns associated with the identification of client needs in the construction of the plan of care include the following:

- What is the nurse’s responsibility if the client is discharged before all short-term outcomes are met?
- Who is responsible for follow-through once the client has been discharged?
- Who is responsible for monitoring client progress toward long-term outcomes?
- Should this information be shared with the client’s admitting/primary physician or office nurse?
- Is the nurse who has made a nursing diagnosis responsible for follow-through to its resolution?
Outcomes identification: The nurse identifies expected outcomes...

- Involves the client, family, and other healthcare providers in formulating expected outcomes
- Derives culturally appropriate expected outcomes from the diagnoses
- Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise
- Defines expected outcomes in terms of the client, client values, ethical considerations, environment, and situation
- Includes a time estimate for attainment of expected outcomes
- Develops outcomes that provide direction for continuity of care
- Modifies outcomes based on changes in the status of the client or situation
- Documents expected outcomes as measurable goals
Outcomes identification: The nurse identifies expected outcomes...

- Involves the client, family, and other healthcare providers in formulating expected outcomes
- Derives culturally appropriate expected outcomes from the diagnoses
- Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise
- Defines expected outcomes in terms of the client, client values, ethical considerations, environment, and situation
- Includes a time estimate for attainment of expected outcomes
- Develops outcomes that provide direction for continuity of care
- Modifies outcomes based on changes in the status of the client or situation
- Documents expected outcomes as measurable goals
Planning: The nurse develops a plan...

- Develops an individualized plan considering client characteristics or the situation
- Develops the plan in conjunction with the client and others
- Includes strategies that address each of the identified diagnoses or issues
- Provides for continuity within the plan
- Incorporates an implementation pathway or timeline
- Establishes the plan priorities with the client and others
- Utilizes the plan to provide direction to others
- Defines the plan to reflect current statues, rules and regulations, and standards
- Integrates current trends and research
- Considers the economic impact of the plan
- Uses standardized language or recognized terminology to document the plan
Measurement Criteria for ANA Standards 3 and 4 (ANA, 2010)

ANA Standard 3: Outcomes identification: The registered nurse identifies expected outcomes individualized to the client.

1. Involves the healthcare consumer, family, healthcare provider, and others in formulating expected outcomes when possible and appropriate.
2. Derives culturally appropriate expected outcomes from the diagnose.
3. Considers associated risk, benefits, costs, current scientific evidence, expected trajectory of the condition, and clinical expertise when formulating expected outcomes.
4. Defines expected outcome in term of the healthcare consumer, healthcare consumer values, ethical considerations, environment, or situation with such considerations a associated risks, benefits and costs, and current scientific evidence.
5. Includes a time estimate for attainment of expected outcomes.
6. Develops expected outcomes that facilitate continuity of care.
7. Modifies expected outcome according to changes in the status of the healthcare consumer or evaluation of the situation.
8. Documents expected outcomes as measurable goals.
ANA Standard 4: Planning: The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

1. Develops an individualized plan in partnership with the person, family, and others, considering the person's characteristics or the situation, including, but not limited to, values, beliefs, spiritual and health practices, preferences, choices, developmental level, coping style, culture and environment, and available technology.
2. Establishes the plan's priorities with the healthcare consumer, family, and other, as appropriate.
3. Includes strategies in the plan that address each of the identified diagnoses or issues. These may include, but are not limited to, strategies for:
   • Promotion and restoration of health
   • Prevention of illness, injury, and disease
   • The alleviation of suffering
   • Supportive care for those who are dying
ANA Standard 4: Planning: The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

4. Includes strategies for health and wholeness across the life span.
5. Provides for continuity in the plan.
6. Incorporate an implementation pathway or timeline in the plan.
7. Considers the economic impact of the plan on the healthcare consumer, family, caregiver, or other affected parties.
8. Integrate current scientific evidence, trend, and research.
9. Utilizes the plan to provide direction to other members of the healthcare team.
10. Explores practice settings and safe pace and time for the nurse and the healthcare consumer to explore suggested, potential, and alternative options.
11. Defines the plan to reflect current statutes, rule and regulations, and standards.
12. Modifies the plan according to the ongoing assessment of the healthcare consumer's response and other outcome indicators.
13. Documents the plan in a manner that use standardized language or recognized terminology.
Reference


2. Lippincott Williams & Wilkins (2013). Nursing Care Planning made Incredibly Easy-2nd edition. Lippincott Williams & Wilkins