Directions for Nursing Care with Functional Health Patterns:

**Long Assessment Plan:** (1 required)

A1. Page one of format:
1. Fill in the front sheet of the assessment. This sheet must be completed prior to giving nursing care. Pay careful attention to the diagnosis that you will be addressing for the patient while in your care. If the patient is admitted for “gastritis” and he is in ICU there must be a new diagnosis (resection with colostomy?), complication (ARDS post op ?) or something more current than the admitting diagnosis. You may need to inquire from staff. Do not just look at “print out census” sheets from the floor, often these are very outdated. Begin integration of patho that shows how 2 disease processes may impact each other (i.e. impacting and/or conflicting) with labs, medications, and treatments. A branching diagram is required with underlining of your patient’s particulars so the information is personalized.

A2. A 2 page paper using APA format (double spaced, 1” margins) is required. Points will be allotted for correct formatting. Address the psychosocial, and developmental level, identifying a theorist (i.e. Erickson etc.) and criteria you are using to evaluate. Be sure to give concrete examples of your patient to substantiate your assessment. Address the socioeconomic information and identify how it impacts your patient’s health care or lack of. Identify patients culture, how it influences his/her medical decisions, medication, alternative medicine, diet etc. Substantiate influence of family or lack of with patient examples then use a minimum of 2 references from psychology or culture texts or journals. One nursing article (a copy attached to paper) (not torn from a journal unless it is your journal) must also be referenced and addressed in the paper. (total 3 references). This may refer to a treatment, medication, procedure or any nursing intervention that may influence or relate to your patient’s care. Perhaps it could be a particular intervention that was not used, and you felt it might have been advantageous. Think of yourself as a true patient advocate promoting exemplary nursing care and interventions.

B1. Subjective Assessments Block:
To complete the subjective data information, obtain data from the following sources: the client, the health history form, the family or the chart. You are encouraged to use the admitting nursing information and the physicians data from the chart. Use the guidelines to elicit information for each area. Address all of the Functional Health Patterns in this manner.

B2. Use the facilitative communication sheet with the directions to record a therapeutic conversation with the client. The issue addressed must be a substantial concern for the client or points will be deducted. See directions for this on the form in the skills manual. You must attain an 88% grade for this exercise.

C1. Objective assessment Block:
Physical assessment: In the objective data block, record your physical health assessment. Use Jarvis for format. Address each Functional Health Pattern. Add any particulars that may be necessary for your patient even if the prompts are not listed.
C2 Lab and Diagnostic block/and additional Lab sheet:
Gather supportive data to substantiate observations with labs, procedures, and other objective data. Lab tests should be reflected in each FHP where it is appropriate, although they may be relevant in more than one FHP. Identify the abnormal values with arrows reflecting high or low values. Then on the “lab sheet” give the values with the significance/meaning of the abnormals for this patient. Be sure to attend to the relevance for your patient. List the normal labs also to demonstrate ruled out problems.

*Confirm that any data that you have used in your NANDA for “as demonstrated by” is documented somewhere.

D. Medication Block/and additional Medication sheet:
Fill in the names of the medications that are relevant for the FHP. Then on the Medication sheet list the information for each medication ordered.

E. The NANDA and Collaborative block This has changed. List only the NAND and/or collaborative problems that apply to your patient. (1) Use the NANDA wording. List at least one or two nursing diagnosis for as many of the FHP as are pertinent. (2) Define the statement by “related to” (etiology here) or “risk for” (Wilkinson, p. xv). (3) May use secondary to (use medical diagnosis here). (4) Using the terms “manifested by” identify the “defining character (Wilkinson, p. xiii) from your data in the subjective and/or objective blocks to verify the diagnosis.

F. Priority list. This has changed. This will now have 5 areas covered. This area will now list on the separate sheet the (1) NANDA wording with priority number and the justification for your listing with a reference. (2) The next area will be the NOC, then patient goal and measurement criteria. (note this is 3 bits of information). (3) The next area is the NIC, then nursing interventions with who, when, how often etc. (Wilkinson p. xvii) and (4) rationale for the specific nursing interventions with reference. (5) The final area is the evaluation of the goal and measurement criteria, how successful it was, and what changes were needed.

For the long care plan you will prioritize 10 nursing diagnoses, give justification for 6 of them, and complete items #2 to #5 from above for the top 3 NANDA you prioritized.

Note: Each goal and nursing activity must be personalized for your specific patient using age, diagnosis, activity, needs etc. Do NOT just copy from Nursing Diagnoses books or programs.
Short Assessment Plan

A. Page one of format:
1. Fill in the front sheet of the assessment. This sheet must be completed prior to giving nursing care. Begin integration of patho that shows how 2 disease processes may impact each other (i.e. impacting or conflicting) with labs, medications, and treatments. Patho must include all the areas listed. See note under long care plan for criteria in selecting a patient’s diagnosis. A branching diagram is required. Underline your patient’s particulars so the information is personalized.

B 1 Subjective Assessments Block:
To complete the subjective data column, obtain data from the following sources: the client, the health history form, the family or the chart. You are encouraged to use the admitting nursing information and the physicians data from the chart. Use the guidelines to elicit information for each area. Address 3 of the patient’s most relevant Functional Health Patterns in this manner.

C 1. Objective assessment Block: Complete all areas of Physical assessment. In the objective data block, record your physical health assessment. Use Jarvis for format. Address all Functional Health Patterns for this area. Add any particulars that may be necessary for your patient even if the prompts are not listed.

C 2. Lab and Diagnostic block/and additional Lab sheet:
Gather supportive data to substantiate observations with labs, procedures, and other objective data. Lab tests should be reflected in each FHP where it is appropriate, although they may be relevant in more than one FHP. Identify the abnormal values with arrows reflecting high or low values. Then on the “lab sheet” give the values with the significance/meaning of the abnormals for this patient. Be sure to attend to the relevance for your patient. List the normal labs also to demonstrate ruled out problems.

*Confirm that any data that you have used for “as demonstrated by” is documented somewhere.

D. Medication Block/ and additional Medication sheet:
Fill in the names of the medications that are relevant for the FHP. Then on the Medication sheet list the information for each medication ordered.

E. In the NANDA and Collaborative block This has changed. List only the NAND and /or collaborative problems that apply to your patient. (1) Use the NANA wording. List at least one or two nursing diagnosis for as many of the FHP as are pertinent. (2) Define the statement by “related to” (etiology here) or “risk for”. (Wilkinson, p. xv). (3) May use secondary to (use medical diagnosis here). (4) Using the terms “manifested by” identify the “defining characteristics” (Wilkinson, p. xiii) from your data in the subjective and/or objective blocks to verify the diagnosis.

F. Priority list. This has changed. This will now have 5 areas covered. This area will now list on the separate sheet the (1) NANDA wording with priority number and the justification for your listing with a reference. (2) The next area will be the NOC, then patient goal and measurement criteria.(note this is 3 bits of information). (3)The next area is the NIC, then nursing interventions with who, when, how often etc.(Wilkinson p. xvii)and (4) rationale for the specific nursing
interventions with reference. (5) The final area is the evaluation of the goal and measurement criteria, how successful it was, and what changes were needed.

For the short care plan you will prioritize 6 nursing diagnoses, give justification for 4 of them, and complete items #2 to #5 from above for the top 2 NANDA you prioritized.

**Note:** Each goal and nursing activity must be personalized for your specific patient using age, diagnosis, activity, needs etc. Do **NOT** just copy from Nursing Diagnoses books or programs.

**Care plans for more than 2 patients:**

**Modified Care plan:** For a patient that has gone home, is newly assigned, or a 2nd patient the following must be completed and turned in. The first page (including a very brief patho diagram) and the priority page with 1 complete nursing diagnosis using the NOC, goals, measurement criteria, NIC, nursing activities, and rationale. You should include any physical assessment and objective data you obtained. It is expected that if you had the patient any length of time, you would have completed at least some of the physical assessment. Evaluate and write up the system that is most pertinent to the diagnosis and list any nursing diagnoses applicable.

When 2 patients are assigned at the beginning, one regular short care plan is due, with one modified short care plan.