INTRODUCTION TO CARE PLANNING DOCUMENTATION

The care plan is where nurses record assessment of patient/client needs and outline the most appropriate ways in which the individual can be provided with the best care available. It is an important record when evidencing patient/client care and for this reason is a key legal document of accountability of nursing care.

As patients/clients, other nurses and in some instances the family have input to the care plan it is also seen as an important communication tool ensuring that everyone is aware of the patient's/client's needs. Learning how to write good care plans is an important skill in this course and therefore it requires frequent attention on clinical placement.

Since 1999 the School of Nursing at the University of Ulster has been developing a structured approach to patient/client assessment and planning care. The rationale for this is that across the various clinical placements there is a lot of diversity. While this is very acceptable in the pluralistic world of nursing, it does make it difficult for the students and teachers to evaluate competency development in relation to this important area. Therefore a consistent approach is aimed at helping the student and teachers see the developmental progress across different placements.

The structure of the University of Ulster care planning system is the result of many influences. Most of the key theories of Nursing (Henderson, Roper, Roy, Neuman, Orem. Rogers, etc) provide the concepts that underpin the assessment. Over the years assessment areas have been added to and subtracted from the assessment sheets by practitioners, mentors, teachers and students. The system you are now being presented with is a result of this process of development.

The University of Ulster care planning system is primarily an education tool. Students are guided through key ideas that affect patient/client need and are encouraged to develop knowledge and skills in relation to holistic assessment of need, making nursing diagnosis, collaborating with the patient and family to get set goals, implementing evidence based care to achieve the set goal and evaluating the effectiveness of the nursing interventions in meeting the goal.

Most importantly it is also recommended that students become familiar with the existing care planning system in each placement facility and become competent in using this in addition to the University of Ulster one. The University of Ulster's care planning system is not to replace anything that has been developed in the placement facility. As an educational tool it is aimed at steering students through the care planning process and providing a consistent approach to student assessment across different placements.

PATIENT ASSESSMENT AND CARE PLANNING FORMS

Name (Pseudonym): …….. Age: …….. Gender: ……..

Student's Name: ……..…… Registration Number: ……..

Placement Module: …… Date: ……

PERSONAL PROFILE
[Health History and Health Perception]

INITIAL ASSESSMENT

Relevant Medical History:

Reason for Admission:

Source of Referral:

Source of Information:

Communication:

Hearing Problems: YES ☐ NO ☐
(if YES provide detail)

Visual Problems: YES ☐ NO ☐
(if YES provide detail)

Emotional State on Admission:

Awareness level:

Glasgow Coma Scale (if applicable) ☐

Medication:

Mobility: YES ☐ NO ☐
Fall Risk done
(Comment)

Moving and Handling assessment done: YES ☐ NO ☐
(Comment)

Allergies YES ☐ NO ☐
(if YES provide brief detail)

Infection Risk: YES ☐ NO ☐

Preliminary Pain Assessment:

General Skin Condition:
Skin Intact: YES ☐ NO ☐
(if NO provide brief detail)

Condition of Pressure Points:

Pressure Sore Risk Assessment Score
(Comment)

Scale Used: ☐

Risk Status:

Airway/Breathing/circulation:
Airway

Breathing Difficulties YES ☐ NO ☐
(if YES provide detail)

Smoker: YES ☐ NO ☐
(if YES provide detail)

Heart Problems: YES ☐ NO ☐
(if YES provide detail)

Heart rate and regularity:
Respiratory rate and regularity:
Blood pressure (mmHg):
Blood gas (if applicable):
Oxygen saturation:
Temperature (indicate route):

Student:…… ***Date:***……

IN-DEPTH ASSESSMENT		
Safe Environment *(risks)*:	**Elimination *(including incontinence)*:** Bowel Function: Bladder Function: **Urinalysis:**	**Pain:** *(use appropriate assessment tool)* Location: Severity: Aggravating factors: Frequency: Patient's description *(eg sharp)*
Skin: **Wound Assessment *(if applicable)*:**	**Level of orientation and neurological state:**	
Diet: **Nutrition/Fluid/Metabolism:** **Weight:** **Height:** **BMI:** **Blood Sugar *(if appropriate)***	**Communication:**	

IN-DEPTH ASSESSMENT *(continued)*

Values-Beliefs-Culture:

Special Considerations:

Sleep-Rest:

Activity-exercise / mobility:

Coping and stress tolerance:

Family/carer perspectives and needs:

Perceptions of self and identity:

SETTING GOALS AND SPECIFYING NURSING ACTIONS

Care Need / Problem / Potential Problem	Goals of Care	Nursing Actions	Evidence-base for actions.
Review Time and Date:			

Signature:…… *Discontinuation date:*…… *Signature:*……

SETTING GOALS AND SPECIFYING NURSING ACTIONS

Care Need / Problem / Potential Problem	Goals of Care	Nursing Actions	Evidence-base for actions.
Review Time and Date:			

Signature:…… *Discontinuation date:*…… *Signature:*……

SETTING GOALS AND SPECIFYING NURSING ACTIONS

Care Need / Problem / Potential Problem	Goals of Care	Nursing Actions	Evidence-base for actions.
Review Time and Date:			

Signature:……. *Discontinuation date:*……. *Signature:*…….

SETTING GOALS AND SPECIFYING NURSING ACTIONS

Care Need / Problem / Potential Problem	Goals of Care	Nursing Actions	Evidence-base for actions.
Review Time and Date:			

Signature:…… *Discontinuation date:……* *Signature:……*

EVALUATION

Time and Date	Need/ problem No.	Comments	Signature

I confirm that the work presented relates to a person in this unit who the student has cared for and is the work of the student

Mentor's Signature:…….. *Student's Signature:……* *Date:……..*

EVALUATION *(continued)*

Time and Date	Need/ problem No.	Comments	Signature

Reference List

I confirm that the work presented relates to a person in this unit who the student has cared for and is the work of the student

Mentor's Signature:…….. Student's Signature:…….. Date:……..

REFERENCE LIST

Reference List