Nursing Care Plan: Meaning And Process Of Creation

A nursing care plan (NCP) is a formal process that includes correctly identifying the existing needs, as well as recognizing potential needs or risks (Vera, 2019). This process consists of an organized assessment of patient health conditions and identification of their problems which is then used in setting appropriate goals, create methods, and apply relevant strategies basing on evidence-based practice. As a nursing care plan is a written reflection of the nursing process, it also acts as a means of communication between nurses and patients and also with other healthcare providers which aids for the best possible patient outcome (NANDA-I). In this assignment, keeping patient's needs and care in mind for patient-centred care, this essay explores various nursing interventions and systemic approaches to the care provided to the patient during the nursing process. Foremost, a patient's health data is collected, assessments are done, then various nursing diagnoses are made identifying actual or potential response of a patient to their health condition which acts as a foundation in choosing the best nursing intervention for patient care. After that, a care plan and goals are set to be achieved by the applications of chosen interventions, and evaluation is done at the end. For this case, Mr. K is a pseudonym given to the patient in order to protect his privacy and maintain confidentiality in accordance with the code of conduct for nurses (AHPRA, 2018).

Mr. K is a 51 years old patient living in an Aged Care home. He was a heavy smoker in the past and has got a medical history of COPD (Chronic Obstructive Pulmonary Disease) and hypertension and is undertaking multiple medications for it. He takes Norvasc 5mg daily, Atenolol 25mg BID, and Clonidine 0.1mg PO q 6 hours which helps him with his hypertension. Currently, he is complaining of his wheezing sound, persistent cough with phlegm, and difficulty in breathing accompanied by the feeling of tightness in the chest. COPD (Chronic Obstructive Pulmonary Disease) is an umbrella term used for a group of progressive lung conditions such as emphysema, chronic bronchitis, and progressive asthma. It is mainly indicated by symptoms like shortness of breath, increased phlegm or mucus production, repetitive cough for a long period of time which doesn't get better, feeling of fatigue, etc (Lung Foundation Australia,2019). In this case, the further assessment was done on Mr. K and his body spO2 (Oxygen Saturation) was 89% and his respiration rate was 28 breaths per minute. During the assessment, he was seen forcing himself to breathe and he was running out of breath even by a short task or movement. Therefore, appropriate nursing diagnosis needs to be made using the NANDA nursing diagnosis list in order to determine an appropriate care plan for the patient (NANDA-I).

The first nursing diagnosis, in this case, is ineffective airway clearance related to(r/t) inflammation of the airways secondary to COPD as evidenced by (AEB) patient having wheezing sound on bilateral upper lobes during expiration. Activity intolerance r/t constriction of airways AEB patient's excessive phlegm production and patient running out of breath by simple tasks or movement can be another nursing diagnosis. The patient is experiencing symptoms like persistent cough with phlegm, feeling of tightness in the chest and difficulty in breathing, so there can be other risks related to it. His persistent cough with phlegm indicates that there is high production of phlegm in his respiratory tract. Due to this, there is a high possibility that this phlegm and any other respiratory secretions may be retained in the respiratory tract which can act as a good medium for bacterial growth (Gulanick & Myers, 2014). Such infection can cause various complications such as pneumonia which can lead to respiratory failure and become life-

threatening for patients with COPD (Villines, 2017). Therefore, another nursing diagnosis can be a risk for infection r/t retained secretions.

On the other hand, he has hypertension and on measuring his BP and observing his medical chart, he had consecutive high blood pressure readings and has a current B.P of 140/80. Blood pressure is the force exerted by blood on the walls of arteries. Its normal range on an average adult is 120/80. Blood pressure is considered to be high if its systolic blood pressure reading is ?140 mmHg and/or diastolic blood pressure reading is ?90 mmHg (WHO, 2019). In this case, the patient isn't complaining about anything related to hypertension but that doesn't mean that he might not any health risks related to it. Hypertension itself is a serious health condition and a major risk factor for chronic health conditions such as heart failure, stroke, chronic kidney diseases, and coronary heart disease (AIHW, 2019). In this case of a patient with hypertension, nursing diagnosis of Risk for impaired cardiovascular function r/t impaired profusion AEB patient's continual hypertensive readings can be made. And as the patient is unable to maintain stable blood pressure, another nursing diagnosis, Knowledge deficit r/t ineffective health management AEB continual hypertensive reading is made. Another very important nursing diagnosis can be the Risk for fall r/t side effects of multiple blood pressure medications (Tinetti et al, 2014). It is important to take into consideration such risks in order to provide the best care plan to patients in order to promote their good health condition.

After these risk assessment and nursing diagnoses are made, goals are set, and a plan is made to meet those goals. For first nursing diagnosis which is ineffective airway clearance r/t inflammation of the airways AEB wheezing sound on bilateral upper lobes during expiration, goal of patient having clear airway after 4 hours as evidenced by patient having clear lung sounds on bilateral upper lobes of during expiration. Respiration rate will be at range of 16-20 breaths per minute. Also, patient will remain free of infection as evidenced by normal temperature, clear breath sounds, negative sputum cultures and normal white blood cell count (Gulanick & Myers, 2014, p.440). Similarly, patient will be able to do daily activities as evidenced by patient having clear airways and no difficulty in breathing. The patient is made ready for exacerbations in case the situation gets worse. On the other hand, for hypertension patient goal can be set as the patient being able to monitor BP, take proper BP reading, record it, interpret it and describe strategies for managing hypertension. Due to the possibility of knowledge deficit patient might be taking medicines incorrectly which is why the patient has continual hypertensive reading. For this, the goal can be set to make patients able to take all prescribed medications as they are prescribed by the doctor. Risk for fall is one of the potential risks. For this, goals can be set to make the patient's environment safe and patient able to ask for help whenever they feel like having an immediate risk for fall due to weakness or dizziness caused due to multiple medications or any other factors.

For achievement of these goals, various nursing interventions are needed to be done. In order to gain effective airway clearance, the patient's vital including spO2 level, respiration rate should be assessed every 4 hours. Assessing the vitals of the patient helps in monitoring the patient's respiratory system and it acts as an indication if there are any unusual situations. Similarly, the patient's respiration and breath sounds should be monitored every 4 hours. Monitoring these gives the indication of respiratory distress and accumulation of fluids if there is any. Similarly, to help the patient breathe easily, beta-2-adrenergic agonists (e.g., albuterol, levalbuterol) should be administered by a metered-dose inhaler (MDI) or nebuliser as prescribed. These medications are short-acting inhaled bronchodilators that gets into action quickly and open up the airway, making it easier to breathe and decrease bronchoconstriction

(Gulanick & Myers, 2014, p.436). Similarly, for Risk for infection, nursing intervention such as encouraging an increase in fluid intake, unless contraindicated can be done. As COPD promotes mucus production due to irritation of the respiratory tract, it can cause that mucus to be thick and sticky making it difficult to cough out. Hence, it will act as a medium for infection. But if a patient intakes enough fluid, it helps in thinning the mucus and aids in keeping the airway clear (Ghosh, Boucher & Tarran, 2015). Also, flu shots should be given after consulting a doctor. This helps to prevent the possible flu infection that might happen in the future which helps to avoid fatal consequences as even a minor infection may lead to severe lung infection in COPD patients as a result of weakened lung power. Patients should be educated on the use of rescue inhalers nebulizers, how to use them and when to use them. The application of these interventions help in clearing the patient's airway which will then help him in performing daily tasks without any difficulty in breathing. Hence, helping deal with activity intolerance.

After the implementation of these interventions, it is possible to evaluate if those goals are met or not. For initial nursing diagnosis of ineffective airway clearance, it can be evaluated by assessing the patient's respiration rate and breath sounds. In the given 4hrs time, evaluation as a patient having effective airway clearance AEB patient having clear breath sounds on bilateral upper lobes during expiration and having respiration rate within the range of 16-20 breaths per minute, can be considered as a goal met. Similarly, for activity intolerance and risk for infection, goals can be considered met if the patient can give the demonstration on how to use nebulizer and inhaler as per their requirement. Verbal feedback and physical demonstration from the patient are also ways to evaluate the set goals and effectiveness of applied interventions. If the patient response is positive, then the goals are considered met. This means the patient having no trouble breathing AEB airway patency and clear breath sounds and the patient not showing any symptoms of infection.

In the case of hypertension, the first intervention that can be done is properly educating the patient on the proper way to take BP and demonstrate the skill back to confirm in case they are doing it themselves time and often. Also, educating them about what those numbers of systolic and diastolic readings mean, in a simpler way, can help them be able to inform the healthcare worker whenever their BP reading appears to be worsening for a long time which can help in avoiding other potential health risks. The result of this intervention can be evaluated by checking patient's self-taken readings during the next check-up and asking how they are feeling about monitoring their BP themselves. This intervention allows patients to closely monitor their own BP readings and therefore, reminds them to do the things they are supposed to such as taking medicines on time or maintain a healthy diet. This intervention hence helps in maintaining healthy BP readings and hence the goal is met. Similarly, for meeting the goal of patients taking medicines as prescribed which is for knowledge deficit r/t ineffective health management, patients should be educated on the importance of medication compliance. This helps to provide them with a rationale for therapy and aids the patient in assuming responsibility for care. As mistakenly doubling the dose or missing the dose, either can be very dangerous in this case, educating the patient about this matter can help in their better health output. After implementation of this intervention, it can be evaluated during the next check-up. If the patient is having a controlled BP reading and verbal communication, the patient can clarify which medicine, when, how, and why they are taking their medication, then it can be considered as goals met and vice-versa. Similarly, goals for Risk for falls can be met by making patient surrounding safe. Call bells can be made available to patients. This helps them to let the healthcare provider know that they are in possible danger and hence helps in the prevention of it. On doing a further assessment on basis of FRAT, Mr. K showed low risk for fall risk status.

Also, safety rounds should be made to keep an eye on patient’s condition and their environment. This can be done at certain time intervals to make sure the patient and their surrounding is safe.

In this way, nursing care plan for Mr. K is made. In this assignment, its main idea was to critically analyse Mr. K’s case study and prepare a nursing care plan for him. For this, first, all required data about Mr. K like his medical diagnosis data was explored. Then, nursing diagnosis related to the case were made and goals were set for the nursing plan. After that, relevant interventions were made and implemented in order to achieve the best patient outcome. At the end, evaluation of the effectiveness of those interventions was done using evidence-based reasons. This is how this nursing care plan is made.