



Nurse Careplan Guide

BEAUTIFUL NURSING LLC

A D P I E

- A Assessment:** collecting subjective and objective data from patient and secondary sources.
Subjective: subjective to change. EX: patient's report of pain.
Objective: information the nurse observes. EX: vital signs, EKG
- D Diagnosis:** Identifying the problem to create a nursing diagnosis. Types: **RISK, ACTUAL, & HEALTH PROMOTION.**
Risk: The patient is at RISK for developing _____ because of health condition/life processes.
Actual: The patient has _____ because of health conditions/life processes.
Health Promotion: a clinical judgement of motivation, desire to enhance wellbeing of patient.
- P Planning:** setting goals to solve problem.
- I Implement:** DO nursing interventions that correlate to goals.
- E Evaluate:** Determine outcome of goals and actions. Did it work? What needs to be changed?

Forming a Nursing DIAGNOSIS

1. The problem/nursing diagnosis use from NANDA
2. Etiology of related to "r/t"
3. Symptoms "AEB"

Example: Acute Pain r/t tissue trauma AEB pain level 9 on 1-10 verbal pain scale.

Forming a Nursing GOAL

A Nursing Goal should be **SMART** and correlate with the nursing diagnosis.

- S: Specific**
- M: Measurable**
- A: Attainable**
- R: Realistic**
- T: Time Framed**

Example: Patient will verbalize a decrease in pain by rating less than 5 on 1-10 verbal pain scale within 24 hrs of receiving pain medication.

Forming a Nursing INTERVENTION

Nursing interventions are treatments or actions that will benefit the patient to meet the goal as stated previously.

Interventions can either be nurse initiated or collaborative.

These interventions should be EB (**evidence-based**) and NANDA provides examples.

Instructor Careplan Teaching Guide For Nurses

RS Peters



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