**HBU Nursing Student Care Plan** Student Name: Date:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Unit/RN** | **Admitting Diagnosis:** | | | | | |
| **Rm# /Admit Date** | Past medical/surgical history (PMHx): Co-morbidities: | | | | | |
| **Age/Gender** |
| **Code Status** | **IV Access** |  |  | **Medication Times (circle)** |  |  |
|  | (PIV, PICC, PORT, IJ, CVAD etc.) |  |  |  |  |  |
|  | L: | 07:00 | 10:00 | 13:00 16:00 | 19:00 | 22:00 |
|  | R:  Fluid/Rate: | 08:00  09:00 | 11:00  12:00 | 14:00 17:00  15:00 18:00 | 20:00  21:00 | 23:00  00:00 |
| **Diet**  (NPO, Full, Renal, etc.) | **Allergies**  NKDA □ | **Drains, Devices, Wounds**  (Foley, JP, Dressings, Restraints, etc). | | | | |
| **Fall Risk** | **Pre-shift Report: From the case study given, create what could be received as a Pre-shift report from the previous Nurse and write it here.**  **Discharge Plan:**  **Teaching:** | | | | | |
| **Isolation** |
| **Blood Type** |
| **Vaccines** |
|  |

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| --- | --- | --- | --- | --- |
| **LABS: Date/Result/Interpretation** Indicate if high, low, or within normal limits (WNL) | | | | |
| Hgb |  | PT/PTT |  | Other relevant labs |
| Hct |  | INR |  |  |
| WBC’s |  | NA+ |  |  |
| Platelets |  | K+ |  |  |
|  | **ABG** | LFT’s if relevant |  |  |
| pH |  | BUN |  | Ordered Diagnostics/Tests |
| PC02 |  | Cr |  |  |
| P02 |  | HgBA1c |  |  |
| Sa02 |  | Glucose |  |  |

**Please attach EKG Strip if applicable**

**Nursing Assessment Findings/Review of Systems:** Chart “by exception.”

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| --- | --- | --- | --- | --- | --- |
| Neuro/Head/Neck  (Mucous Membranes, Glasses, Hearing Aids,  NVS/ Pupils, Cranial nerves, motor function, Clonus, Seizures, Gait, etc.) | | Respiratory  (Rate, Rhythm, Pattern, O2 needs, Cough, Trach/Suctioning etc.) | | GI  (Abdomen, Bowel sounds, Bowel Routine, Last BM) | Integ./MSK/Mobility  (Skin, Turgor, Wounds/Incision (s), Hair, Nails,  ROM, Safety Concerns e.g. call bell in reach, bed alarm, restraints etc.) |
|  | |  | |  |  |
| Nutrition/Endocrine  (Diet, % of meals taken, BG/Trends, Tube Feeds, TPN) | | CV  (Heart Sounds, Pulses, Rhythm, Cap. Refill,  Extremities, Pedal Pulses, Weight Attach EKG to back) | | GU  (Urinary pattern, Total output, Catheters, Kidney function, Dialysis etc.) | Psychosocial  (Emotional State, family dynamics, spirituality,  pertinent health determinants, Legal/Ethical Issues) |
|  | |  | |  |  |
| 1. Priority/Nursing dx. | Assessment (as  evidenced by) | | Plan (Goal- short term or  long term) | Rationale for Goal(s) | Intervention (Skills Used/Patient Teaching) |
|  |  | |  |  |  |
| Evaluation/Follow Up: | | | | | |
| 2. Priority/Nursing dx. | Assessment (as  evidenced by) | | Plan (Goal- short term or  long term) | Rationale for Goal(s) | Intervention (Skills Used/Patient Teaching) |
|  |  | |  |  |  |
| Evaluation/Follow Up: | | | | | |
| 3. Priority/Nursing dx. | Assessment (as  evidenced by) | | Plan (Goal- short term or  long term) | Rationale for Goal(s) | Intervention (Skills Used/Patient Teaching) |
|  |  | |  |  |  |
| Evaluation/Follow Up: | | | | | |

# Pathophysiology Algorithm

Clinical Manifestations of YOUR client (objective/subjective)

Treatment for your client

General Treatment

Relevant DoH (min. 3) and Rationale

Gender, health services, environment/working conditions, education and literacy, physical environment, social support networks, personal health practice and coping skills, social environments, healthy child development, biology and genetic endowment, culture, financial and social status

Complications

General Objective/Subjective

Clinical Manifestations

Diagnosis:

Diagnostic Findings

*1-2 credible (published in the last 5 years and peer reviewed) articles or other credible reference(s) required*

Etiology that led to the medical diagnosis:

Pathophysiology-What is occurring at the cellular/tissue and/or system level?

Risk Factors

# SCHEDULED MEDICATION WORKSHEET

**Student Date Unit & Room**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug Name (Generic & Trade Name)** | **Class/Action/**  **Side Effects Common and SEVERE** | **Dose/ Route/Frequency**  **Is the order within recommended dosing**  **limits?** | **Rationale for your Patient** | **Order frequency & Time(s) you**  **actually gave** | **Lab values/Nursing implications**  **(e.g. if giving K supplement what was the most recent K+ lab? Or if giving insulin what was the blood sugar? If giving cardiac meds what is the apical heart rate/vitals?)** |
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