STEPS IN INDIVIDUALIZING A STANDARDIZED CARE PLAN

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INTRODUCTION

In modern India, the field of Nursing is evolving quite steadily so we get plenty of Nursing personnel to deliver a quality of Nursing care for the society in future. As a full fledged Nurse / Student Nurse they should be aware of the concept of providing holistic care to the patients with available resources. By exercising this they will be able to write the individual care plan' from standardized care plan. It may be feasible only in the hospitals where the Nurse patient ratio is maintained.

Library is a temple of knowledge. Books are God of this temple. In Nursing we are totally or partially depending on western books, where it is focusing on their individual needs and problems with available resources existing in this country. All the human beings are more or less same in meeting their basic needs. In this way we may utilize lot of western books for making individualized care plan.

To make individualized care plan the following 10 steps can be followed.

To understand easily we shall take the following situation as an example: -

SITUATION

Mary G. 50 years old woman, who was hospitalized in terminal stage of lung cancer, is bedridden for the past three weeks with the complaints of severe bone pain and metastatic lesion. She has four children they are between 13 to 19 years old. Mary and her husband have been trying to prepare the children for the death. They have no other family members living near by.

Step I: **Read the admission sheet and the medication administration chart of assigned client.**

It is noticed that Mary is 50 year old woman who is Protestant Christian in the IV stage of cancer.

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[at the time of writing this article]

Medication ordered

Inj: morphine sulphate 10 mg bd

Inj: Phenergan 25 mg 10 every 6 Hrs.

Step 2: **Review the history, current diagnostic results, physician progress notes and current consultation.**

She had lobectomy three years ago and experienced recurrence one year ago. Treated with chemotherapeutic drugs until three months ago. When she selected to stop the treatment, she had metastasis in spine, ribs and pelvis.

Mary's condition is steadily deteriorating and the goal of care is to keep her comfortable.

A diagnostic test reveals RBC, HB and serum – protein levels are decreased.

Mary needs assistance in all activities because she has not had a bowel movement for six days. Voiding adequate amounts and I/O are balanced. She is depressed and often crying.

Step 3: **Interview the client and complete assessment by using the tool provided by nursing school of yours clinical facility**

[Refer step No. 7 for knowing the signs and symptoms of Mary's condition]

Step 4: **Highlight the patient data as subjective and objective data**

Step 5: **Read about the disease condition, Nursing diagnosis in recent books and journals, if possible we can use website also.**

Step 6: **Select the appropriate standardized care plan from the text, based on Indian health practice system and available sources.**

Based on the physician statement she needs terminal care. It is determined that the appropriate care plan for Mary with cancer of the lung, we need nursing diagnosis on terminal care and immobility.

Step 7: **Give preference for carrying out the medical order which is called collaborative diagnosis and independent Nursing diagnosis.**

Numerous diagnosis can be made according to the etiologic factors on cancer lung in related to terminal care and immobility of this patient. Based on the above nursing care plan we can find out the following nursing diagnosis, based on the priority.

A. Ineffective breathing pattern R/T diminished lung and chest wall expansion associated with compression of lung tissue by tumor, weakness, abdominal distension and reluctance to breathe due to pain.

B. Ineffective airway clearance R/T stasis of secretion associated with decreased mobility, difficulty in coughing and impaired ciliary function.

C. Pain R/T bone metastasis [back, rib, pelvic region]

D. Constipation R/T back and pelvic pain when attempting to use bedpan, decreased gravity of filling lower rectum due to horizontal positioning and also due to weakness of abdominal muscles associated with decreased activity due to morphine sulphate and decreased intake of fluids.

E. Grieving R/T changes in the body image

Step 8: **Make priorities over the independent nursing diagnosis because, Mary is terminally ill,**

(The top 4 priorities of care were already mentioned in step no.-7)

Step 9: **Modify the desired outcome or goals, so that they are measurable and realistic for your client establish appropriate target like days/time**

Example

Short term goals and long term goals.

NOTE: I took Constipation as an example for illustrating this step.

STANDARDIZED Book sources)

Outcome from care plan on Immobility

The client will not experience Constipation as evidenced by, →

a. Usual frequency of bowel movement.
b. Passage of soft, formed stool
c. Absence of abdominal distension and pain, feeling of rectal fullness or pressure and stressing during defecation.

a) Out come from plan of terminal care
The client will maintain a bowel routine that provides optimal comfort.

INDIVIDUALIZED
Mary may have resolution of constipation as evidenced by
a. Observe for frequency of bowel movements.
b. Passing a soft-formed stool atleast every other day.
c. Absence of increased abdominal distension, abdominal pain, feeling of rectal fullness & pressure and straining during defecation.

Outcome from plan of terminal care: See as above.

Step 10: Select the causes and nursing actions that are relevant clients care.

A. Individualizing the causes from book picture

Standardized Care Plan on Immobility
Constipation related to
A. Diminished defeation reflex association with:
1. Suppression of urge to defecate because of reluctant to use bedpan.
2. Decreased gravity filling of lower rectum resulting from horizontal positioning
B. Weakened abdominal muscles associated with generalized loss of muscle tone resulting from prolonged immobility.
C. Decreased gastro intestinal motility associated with decreased activity and the increased sympathetic nervous system activity that occurs with anxiety.

Care Plan on terminal care
A. Diminished defecation reflex associated with decreased nervous system responses in terminal state suppression of the urge to defecate because of reluctance to use bedpan and decreased gravity filling of lower rectum resulting from horizontal positioning.

B. Decreased ability to respond to the urge to defecate associated with weakened abdominal muscles, impaired physical mobility and decreased level of consciousness.
C. Decreased gastro intestinal motility associated with decreased activity, increased sympathetic nervous system activity that occurs with anxiety and use of some medications (Eg: Analgesics antacids containing aluminum or calcium.
D. Decreased intake of fluids and foods in high fiber.

INDIVIDUALIZED
Constipation related to
A. Diminished defecation reflex association with
1. Suppression of urge to defecate because of increased back and pelvic pain when attempting to use bedpan.
2. Decreased gravity filling of lower rectum resulting from horizontal positioning.
B. Weakened abdominal muscles associated with generalized loss of muscle tone resulting from prolonged immobility.
C. Decreased gastro intestinal motility associated with decreased activity and the increased sympathetic nervous system activity that occurs with anxiety and pain.
A. Diminished defecation reflex associated with decreased nervous system responses in terminal state suppression of the urge to defecate because increased back and pelvic pain attempting to use bedpan and decreased gravity filling of lower rectum resulting from horizontal positioning.
B. Decreased ability to respond to the urge to defecate associated with weakened abdominal muscles impaired physical mobility and decreased level of consciousness.
C. Decreased gastro intestinal motility associated with decreased activity, use of morphine sulphate and increased sympathetic nervous system activity that occurs with anxiety and pain.
D. Decreased intake of fluids and foods in high fiber associated with anorexia.

B. INDIVIDUALIZING THE NURSING ACTIONS FROM BOOK PICTURE
Add or modify the actions to meet the needs of your particular client.

Include medication, treatment client preference and action that will facilitate the achievement of the desired client outcome.

3. Then give care and evaluate the patient care based on the date fixation, etc.

The process of individualization of nursing care is demonstrated below using the nursing diagnosis of constipation as pro type:-

Here by, we can get information from two areas of diagnosis based on Mary's condition.
1) Action from care plan on immobility.
2) Action from care plan on terminal care.

On the basis of above two nursing diagnosis, the constipation has been taken to explain the individualized nursing care plan.

STANDARDIZED
A. Ascertain client's usual elimination pattern.
B. Assess the signs and symptoms of constipation.

For e.g., frequency in bowel movement, passage of hard formed stools, Anorexia, abdominal, distension feeling of fullness of pressure in rectum, straining during defecation.
C. Asses the bowel sound, and report if any changes in a pattern of decreasing –bowel sound.
Implement the measure to prevent constipation
A. Encourage client to defecate wherever the urge is felt.
B. Place the client in high fowler's position for bowel movement unless contraindicated.
C. Encourage client to relax, provide privacy and have call signal within reach during attempts to defecate measures to promote relaxation enable client to relax the animuscles and external anal sphincter which facilitates evacuation of stool.
D. Encourage client to establish regular time for defecation preferably an hour af- →

ter a meal.
E. Instruct client to increase intake of foods high in fiber (eg) cereals, fresh fruits
F. Instruct client to maintain a minimum fluid intake of 2500 ml/day unless contraindicated.
G. Encourage client to drink hot liquids upon arising in the morning in order to stimulate peristalsis.
H. Encourage client to perform isometric abdominal strengthening exercise unless contraindicated.
Increase activities are allowed
I. Administer laxatives or cathartics and enemas if ordered.
J. Consult Physician about checking for an impaction and digitally removing stool if client has not had bowel movements for 3 days if she or he is passing liquid stool or if other signs and symptoms of constipation are present.

(Action from care plan on terminal care)
A. Assist client to the toilet or bedside commode or place in high fowler's position on bedpan for bowel movements contraindicated.
B. If client is taking antacid containing aluminum or calcium, consult physician about alternatives than with antacids containing magnesium.

INDIVIDUALIZED
A. Omit, since bowel habits are already known.
B. Assess Mary for signs and a symptom of constipation, which is mentioned, is standardized care plan [Absence of bowel movement, passage of hard formed stool increased anorexia and abdominal distention and pain.
C. Assess bowel sounds report a pattern of decreasing bowel sounds.

(Implement the measure to relieve Mary's constipation.)
A. Encourage Mary to defecate whenever the urge is felt.
B. Place Mary on bedpan in high fowler's position for bowel movement.
C. Turn on soft music, provide privacy and have call signal within reach during attempts to defecate.
D. Encourage Mary to attempt to defecate about an hour after breakfast.
E. Offer cereals and fresh fruits for breakfast, encourage fiber food in dinner. [Likes and dislikes of patient should be considered]
F. Encourage Mary to increase her fluid intake of 200ml of Apple juice or water every hour while she is awake.
G. Offer hot tea with breakfast.
H. Omit, it is not applicable in terminally ill patient.
I. Omit, if not applicable. Administer the medication as prescribed by physician
J. Consult Physician about checking for an impaction and digitally removing stool since Mary has not had a bowel movement for 6 days and other signs and symptoms of constipation are present.

Action care plan on terminal care
A. Omit action already covered by referral to care plan and immobility since Mary is not able to get to the bathroom or sit on bedside commode.
B. Omit, not applicable.

- So the above 10 steps can be useful in formulating individual nursing care plan. According to this we can make the plan as follows.
- Data
- States has not had bowel movement for six days
- Bowel sounds hypo active
- Abdomen firm and distended
- Bedridden for three weeks
- Consuming only 10% of meals.
- State usually has bowel movement q.o.d. after breakfast.
- Activity, bed rest requires assistance with all activities receiving morphine sulphate every 2 hours

Nursing Diagnosis
Constipation related to
a) Diminished defecation reflects associated with decreased nervous system responses in terminal state suppression of urge to defecate because of increased back and pelvic pain when attempting to use bedpan and decreased gravity filling of lower rectum resulting from horizontal positioning
b) Decreased ability to respond to urge to defecate associated with weaken abdominal muscle and impaired physical mobility.
c) Decreased G.I.T. motility associated with decreased activity use of morphine sulphate and increased sympathetic nervous system activity that occurs with anxiety and pain.

Objectives/Desired Out come: Refer step No. 9
Nursing Action: Refer step no 10 (b)

After writing the nursing care plan, we can deliver the care based on the nursing care-plan and finally, we can evaluate the care given. Based on the evaluation we can re plan the nursing care plan if there is no expected outcome.

CONCLUSION
As per the above discussion, nursing care is client centered, goal directed and coordinated, results in personalized care and effective problem resolution that promotes clients and family function after discharge and return to the community. I hope it may be helpful for student to make well-individualized care plan for giving optimum care for the patient.

Books
1. Ulrich, Canale, Wendell (1998) Medical-Surgical Nursing Care Planning Guides (4th edition); Philadelphia, W.B. Saunders Company, C,h 5, 6 Pp 2-8, 125-146.
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3. Esther Sirra (1999). Nursing Process (1st edition); New Delhi, B.I Churchill Livingstone Pvt. Ltd., Ch 6–11, Pp 25-90.

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PREP (1996), care Planning The Role of Nurse.
Nursing Times, Volume 92, Pp 4-8