

**University of Southern Maine**  
**College of Nursing and Health Professions**  
**NURSING CLINICAL WORKSHEET and CARE PLAN**

**Student Name:** \_\_\_\_\_ **Instructor:** \_\_\_\_\_ **Date of Clinical:** \_\_\_\_\_

**ALERT: All information must be HIPAA compliant!!**

PATIENT: DECADE: \_\_\_\_\_ GENDER: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

ADMISSION DIAGNOSIS: \_\_\_\_\_

*\* starred section to be completed prior to clinical day*

- I. \*CLIENT HISTORY (What precipitated this admission to the hospital? Identify other patient co-morbidities and history.)
  
- II. \*PATHOPHYSIOLOGY (Based on this history and your reading of the record, describe the pathophysiology of the primary and one other diagnosis and relate each to the manifestations that are evident in this patient. What are the risk factors for this disease and describe two potential complications. State your sources of information.
  
- III. \*CURRENT/RECENT DIAGNOSTIC TESTS/PROCEDURES (Dates and results: for example: surgeries, CXR, 12-lead ECG, scans.)
  
- IV. \*CURRENT NURSING INTERVENTIONS (check and describe)

	Describe Parameters or Specific Orders
Nasogastric Suction	
Feeding Tube (NG/GT/JT)	
Glucose checks	
Colostomy/Ileostomy	
Foley Catheter	
Nephrostomy tubes/stents/supra pubic tubes	
Chest Tubes	
O <sub>2</sub>	
Oximetry	
CPT ( )chest physical therapy	
Ventilator	
Tracheostomy	
Drains – Hemovac, JP, Intercranial	
Central Line(s): What type? What's infusing at what rate?	
Peripheral Line(s): What's infusing at what rate?	
Saline Lock - Location	
Casts	
Traction	
Pacemaker/Telemetry Monitor	
Baseline Vital Signs	
Neuro Checks	
I & O Maintained	
Dressing Change	

		<b>Describe Parameters or Specific Orders</b>
Mobility/ADL Level		
ROM Exercises		
TED Hose		
Compression Devices (SCDs)		
Special Bed/Mattress		
Restraints		
Precautions (what type?)		
PCA (patient controlled analgesia) drug and pump settings		
Other		
Other		

V. \*LABORATORY RESULTS (Why is it important to know this result for THIS patient, whether normal or abnormal). Add lab tests as needed for this specific patient)

NORMAL ADULT VALUES		DATE TIME	DATE TIME	DATE TIME	Definition and Purpose of Lab Why is this important for this pt.	Reason for Abnormal
Glucose	70-105					
Sodium	136-145					
Potassium	3.5-5.0					
Chloride	98-112					
HCO3	22-31					
BUN	7-21					
Creatinine	0.5-1.					
Total Protein	6.0-8.3					
Albumin	3.5-5.0					
Calcium	8.9-10.3					
WBC	4.8-10.8					
Hgb	12.0-16.0					
Hct	37-47					
Platelets	140-440					
PTT	25-30					
Protome	11.5-13.1					
INR	0.7-1.2					
CPK	38-120					
LDH	100-190					
AST (SGOT)	5-35					
ALT (SGPT)	7-56					

T Bili	0.2-1.3					
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Other labs as indicated:						
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VI. **\*MEDICATIONS:** List all medications, including IV, IM, PO, SC, and PRN (for continuous IV drips, provide dose in mg/min, mls/hr, etc.)

Dose, Route, Frequency Safe Dosage Ranges	DRUG CLASS/ DRUG ACTIONS	MAJOR SIDE EFFECTS/ FOOD DRUG INTERACTIONS	REASON FOR USE in this Client	NURSING IMPLICATIONS Example: Monitoring, how to give, values to check before administering

VII. **\*SAFETY PLAN \*** (What do you identify as safety concerns? What did you do to ensure your patient’s safety?)

VIII **\*SPECIFIC THERAPEUTIC COMMUNICATION SKILLS/TECHNIQUES:** What verbal and non-verbal strategies do you plan to implement? Which ones did you actually implement?

IX. **\*DISCHARGE PLAN/NEEDS** (Where will this patient go on discharge? What is the anticipated need for care/services?)

X. **NUTRITION SUPPORT**  
 Current Diet (route, type and pt. tolerance) and any special feeding schedule  
 Clearly state nutrition status as: **1.** malnourished, **2.** borderline, requiring some intervention, or **3.** satisfactory. Give your rationale for this status which should be based on clinical observations, laboratory data, diet history, calculate height/weight ratio (BMI), and psycho-social data.  
 If patient is receiving tube feedings or TPN, calculate calories needed based on weight/height ratio. Consult height/weight data (BMI). If on calorie count or supplemental feedings, please state rationale.

XI. **DEVELOPMENTAL INFORMATION.** Describe expected development level based on age. Use your health assessment textbook or handouts to determine expected developmental level. Identify normal development or abnormal development if present for your client based on your own data collection. State two nursing interventions to promote appropriate activity.

XII. **CLINICAL ASSESSMENT FINDINGS** (Do during clinical shift):

Neurological/Neurovascular:

Pain:

Mental Status:

Cardiovascular:

Respiratory along with ABGS with interpretation (if appropriate):

Gastrointestinal/Nutrition:

Renal/Fluid Balance/GU:

Integument:

Functional/Musculoskeletal:

Learning Ability/Needs

Psychosocial/Family – (Describe family, support system, interactions and coping mechanisms.)

- XIII. Web and Nursing Care Plan: Include at least two priority nursing diagnoses and the expected outcomes, interventions, and an evaluation of patient progress.

<b>NURSING DIAGNOSIS</b> Include Etiology/Manifestations	<b>EXPECTED OUTCOMES</b>	<b>INTERVENTIONS</b>	<b>EVALUATION</b>