ADULT HEALTH NURSING

NURSING CARE PLAN – 1

Patient Profile

Name of Patient: _____

Gender: _____ Age: _____

Ward No.: _____ Bed No.: _____

Registration No.: _____ Date of Admission: _____

Address: _____

Religion: _____ Educational Status: _____

Marital Status: _____ Occupation: _____

History of Patient Illness: _____

Onset of Illness: _____

Duration of Illness: _____

Medical Diagnosis: _____

Patient History

Chief complaints	Duration
1.	
2.	
3.	
4.	
5.	

BURN WOUND ASSESSMENT-1

Identification Data

Name of Patient: _____ Age: _____

Gender: _____ Educational Status: _____

Occupation: _____ Blood Group: _____

Marital Status: _____ Religion: _____

Name of Husband: _____ Address: _____

Date of Admission: _____ Date of Discharge: _____

Reg. No.: _____ Obstetrical Score in Case of Women: _____

Chief Complaints: _____

_____

_____

Medical Diagnosis: _____

_____

Assessment

General appearance: _____

General condition: _____

Orientation: _____

Level of consciousness: _____

Speech: _____

Body built: _____

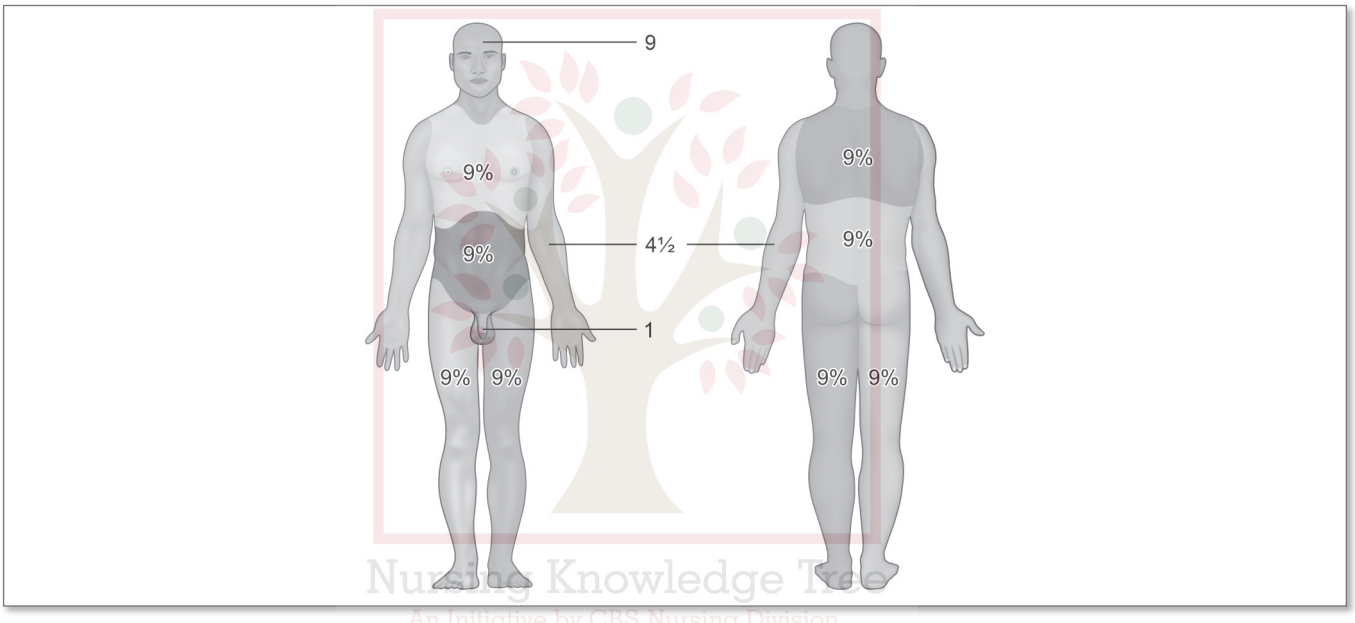
Vital Signs

Temperature: _____ Pulse: _____

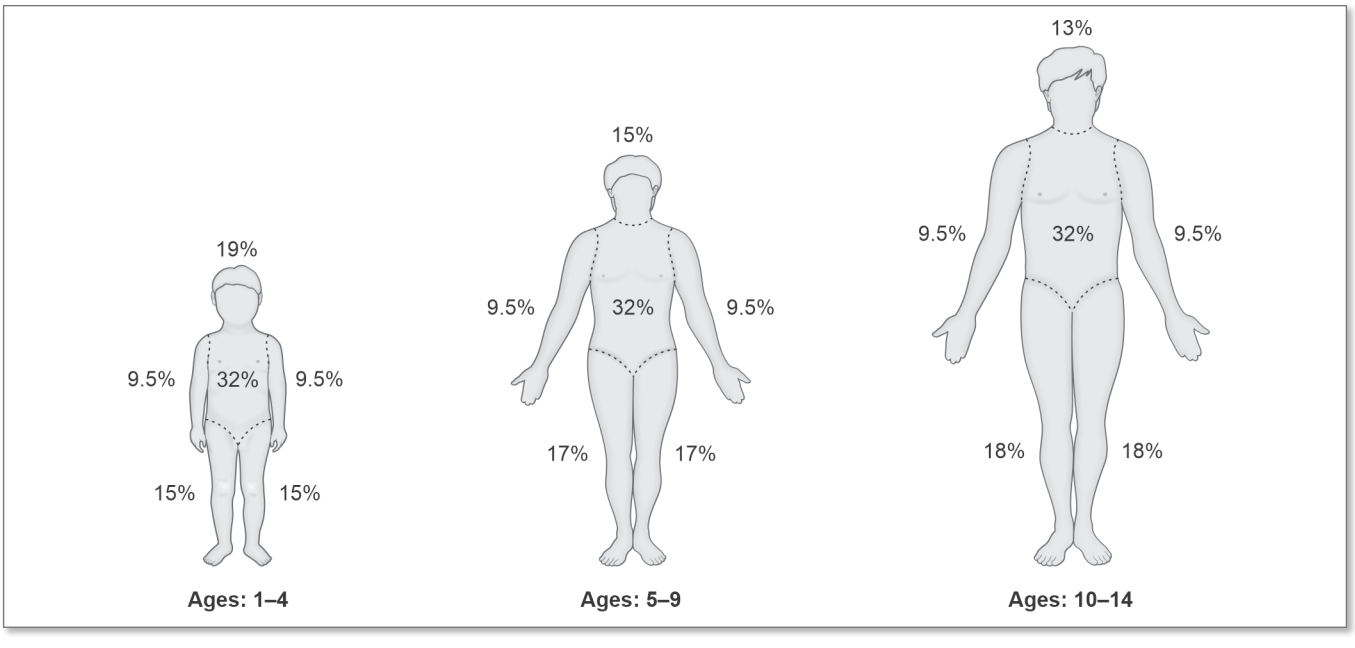
Respiration: _____ Blood pressure: _____

Total body surface area: _____

To calculate burn area, use the rule of nines for adult age (>14 years)



Adult



Children: 1–14 years

MIDWIFERY/OBSTETRICS AND GYNECOLOGY (OBG) NURSING

ANTENATAL CARE AND ASSESSMENT

ANTENATAL EXAMINATION

Introduction

Antenatal examination is the assessment of a pregnant woman and the condition of her growing fetus in the uterus.

Objectives

- To detect any deviation from normalcy.
- To promote good physical health of mother.
- To calculate expected date of delivery, period of gestation and compare the growth of fetus by assessing abdominal girth.
- To detect the high-risk condition of both mother and fetus and prevent complication.

Points to Keep in Mind

- Explain the procedure to mother and its purposes, importance to gain cooperation.
- Maintain privacy
- Ask mother to empty her bladder before starting procedure.
- Check all investigations like ultrasonography for any high-risk.
- Avoid too much manipulation in abdomen, it stimulates contraction.
- Check mother for any type of discharge from vagina.

Articles

- Hand washing article
- Bed examination
- Screen
- Examination sheet
- Urine testing articles for albumin and sugar.
- Weighing machine and measuring scale to measure height of mother.
- BP apparatus.
- Tape measure
- Stethoscope/Fetoscope/Doppler machine.
- History sheet to write the history of the mother.

Procedure

There are two examinations to perform, i.e., (1) General and (2) Obstetrical examination.

Nursing action	Rationale
Keep all articles ready in the examination room.	To save time and energy.
Greet the woman and explain the procedure to her.	Gain confidence and cooperation.
Screen the patient.	Provide privacy make the woman comfortable.
Stand on the right side of the patient.	Make easy to examine.
Warm hand before touching the patient.	Cold hand give spasm to muscle.
Explain importance of antenatal examination.	Prepare mother for examination willingly.
Take history regarding medical and surgical problems, blood transfusion, family history, multiple pregnancy, mental illness, etc.	Calculate expected date of delivery.

ANTENATAL ASSESSMENT

Patient Profile

Name of the Hospital: _____ Ward: _____

Registration No.: _____

Name: _____ Age: _____

Husband's Name: _____

Education of Husband: _____

Education of Wife: _____

Occupation of Husband: _____

Occupation of Wife: _____

Religion: _____ Duration of Marriage: _____

Hemoglobin (Hb):_____ Blood Group: _____

Monthly Income: _____

Address: _____ Post Office: _____

Tehsil: _____ District: _____

State: _____ Nationality: _____

LMP: _____ EDD: _____

GPLA (Gravida, Para, Live, Abortion): _____

Date of Admission: _____ Time: _____

Admission: _____

Pregnancy: _____

Date of previous delivery: _____

Nature of delivery: _____

Obstetrical history: Yes/No. If yes, specify: _____

CHILD HEALTH NURSING

NURSING CARE PLAN

Identification Data

Name of Baby: _____ Age: _____

Father's Name: _____ Bed No.: _____

Ward: _____ Sex: _____

Address: _____

Date of Admission: _____

Diagnosis: _____

Dr In-Charge: _____

Chief Complaints

_____

_____

_____

_____

_____

History of Present Illness

_____

_____

_____

_____

_____

Present Medical History

Present Surgical History

History of Past Illness

Birth History

_____

_____

_____

_____

Dietary History

_____

_____

_____

Immunization History

For infants:

Vaccines	When to give	Dose	Route	Site	Given: Yes/No	Remarks
BCG	At birth or as early as possible till one year of age	0.1 mL (0.05 mL until 1 month of age)	Intradermal	Left Upper Arm		
Hepatitis B Birth Dose	At birth or as early as possible within 24 hours	0.5 mL	Intramuscular	Anterolateral side of mid thigh—Left		
OPV Birth dose	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral		
OPV 1, 2 and 3	At 6 weeks, 10 weeks and 14 weeks	2 drops	Oral	Oral		
fIPV (fractional Inactivated Polio Vaccine)	At 6 and 14 weeks	0.1 mL	Intradermal	Right Upper Arm		

Contd…

COMMUNITY HEALTH NURSING

COMMUNITY HEALTH ASSESSMENT – 1

Community Needs Assessment to Identify Health Determinants

Community health needs assessment is a systematic process to identify and analyze community health needs and assets in order to prioritize these needs, plan, and act upon significant unmet community health needs.

Objectives

_____

_____

_____

_____

Factors Affecting Health

_____

_____

Health Status of the Population

_____

_____

_____

_____

Steps in a Need Assessment

Exploration and identification: _____

_____

_____

Data gathering and analysis: _____

_____

_____

_____

Utilization: _____

_____

_____

Evaluation: _____

_____

_____

_____

_____

Four Types of Community Need

Perceived need	Expressed need	Absolute need	Relative need

Role of Community Health Nurses

_____

_____

_____

_____

_____

_____

_____

_____

Identify Relevant and Appropriate Source of Information

Information such as number of:

1. Eligible workers: _____

2. Pregnant mothers: _____

3. Births: _____

4. Deliveries: _____

5. Abortions: _____

6. Children: _____

Develop Team Strategy

_____

_____

MENTAL HEALTH NURSING

HISTORY TAKING

Patient Profile

Name of Patient: _____

Gender: _____ Age: _____

Ward No.: _____ Bed No.: _____

Registration No.: _____ Date of Admission: _____

Mode of Admission: _____ Identification Mark: _____

Address: _____

Religion: _____ Educational Status: _____

Marital Status: _____ Occupation of Patient: _____

History of Patient Illness: _____

Onset of Illness: _____

Duration of Illness: _____

Diagnosis: _____ Provisional Diagnosis: _____

Final Diagnosis: _____

Relationship with informant (if other than the patient): _____

Name of the informant: _____

Duration of stay with the patient: _____

Source of referral: Self/Another patient/Hospital/Doctor/Any other (specify): _____

_____

Chief complaints: _____

_____

_____

_____

_____

_____

Onset of disease: _____

_____

Duration: _____

Intensity: _____

Predisposing factors: _____

History of Present Illness

Symptoms	Onset	Duration	Course
1.			
2.			
3.			
4.			
5.			

History of past medical and psychiatry illness: _____

_____

_____

_____

_____

History of past psychiatry illness: Yes/No: _____

No. of previous episodes: _____

Duration of each episode: _____

History of psychotropic medication therapy (ECT): _____

_____

_____

_____

_____

Past history of substance use (Alcohol/Multiple substances): _____

_____

_____

_____

_____

Treatment history: _____

_____

_____

_____

Family history: _____

_____

_____

_____

_____

Family Tree

Types of family: _____

Family history of mental illness: _____

_____

_____

History of suicide in the family: Yes/No. If yes, specify: _____

Family history of similar or other psychiatry illness: _____

Describe each family member briefly:

Sl. no.	Name of the family members	Relationship with patient	Age/Gender	Educational status	Occupational status	Health status	Age and mode of death if any