

**NZ Diploma of Enrolled Nursing**

**NURS4415 Foundations for Enrolled Nurse Practice**

**2024**

**General Health Assessment &**

**Plan of Nursing Care**

**NURS4415**

**Ākonga name & ID number:**

**Preceptor name & NCNZ registration number:**

**Clinical placement location:**

**Dates of placement:**

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| **Instructions****Part A** **General Health Assessment**1. **Identify a suitable client/resident** with your supervising Registered Nurse (RN)/Enrolled Nurse (EN) who they consider would be appropriate to complete your General Health Assessment and Plan of Care
2. **Complete the client/resident consent form**. This is to be signed by the RN and your clinical lecturer.
3. **Complete** **general health assessment** using the template provided. Include information from the client/resident file and your own observations.
4. **Identify focused assessment tools in the assessment** that have been used to gather data. Include the results of these focussed assessments in your main assessment. e.g. blood glucose test, blood pressure recording.

**Part B****Plan of Nursing Care**1. **Identify ONE (1) health problem or need** for your client/resident.
2. **Identify and discuss TWO (2) nursing interventions** that you have performed for the delivery of safe and competent client care. **Include the rationale** for these intervention(s) with supporting academic literature. (e.g. Tabbner’s text)
3. **Describe how you would evaluate** whether the desired goal has been achieved OR evaluate the effectiveness of the care.
4. **Once completed, have your RN/EN preceptor sign the assessment as being accurate (on front page).**

Reference:Adapted from: Koutoukidis, G & Hughson, J 2021, *Tabbner’s nursing care: Theory and practice*, 8th edn, Elsevier, Sydney.  **NZ Diploma of Enrolled Nursing****NURS4415 Foundations for Enrolled Nurse Practice** **Declaration of Verbal Informed Consent**I (your name)………………………………confirm that verbal permission has been sought from the client/resident to complete this learning activity and that they are aware that no identifying information will be included in my work.Ākonga Name ………………………………………………………………Signature ………………………………………………………………Verifying Nurse – RN/EN ………………………………………………………………Signature ………………………………………………………………Date ……………………………………………………… |
| **Part A****General Health Assessment****Client Profile:** (maintain confidentiality) * *Age/ Gender*

**Reason(s) for Admission**: (Main problem(s))* *Where were they admitted from – hospital, home, another facility?*
* *Reason for admission*

**Medical/ Surgical History** (within last 5-10 years)* *Relevant health history – check old notes/inter-RAI*
* *Allergies/ Sensitivities*
* *Medication*

**Body Systems Approach****Neurological*** *Headaches, seizures, fainting spells, dizziness*
* *Language, primary, speech, unimpaired, slightly impaired, severely impaired*
* *Memory – short/long term*
* *Mental status – alert, orientated, mildly disorientated, confused, completely disorientated*
* *Cognitive Assessment Score (EG MOCA, MMSE)*

**Sensory*** *Vision – aids*
* *Hearing – aids*
* *Tactile – sensory, touch, tingling, numbness, weakness*

**Cardiovascular*** *Extremities – colour, temperature, sensation, oedema*
* *Blood pressure*
* *Pulse rate and characteristics*

**Respiratory*** *Breathing – rate, depth and at rest/on exertion*
* *Any alteration related to anxiety/stress – measures that assist*
* *Cough – productive/non-productive.*
* *Colour of sputum – quantity*
* *Pain on respiration*
* *Smoker – how many/ how long?*
* *Colour of lips, earlobes and nails*
* *History – asthma/ bronchitis*
* *Oxygen therapy*
* *Oxygen saturation*

**Gastrointestinal*** *Dietary intake – special needs, preferences, food allergies*
* *Any alteration in appetite – amount and types of food eaten*
* *Swallowing difficulties/ indigestion/ nausea/ vomiting*
* *Any significant weight loss or gain – usual weight – height - BMI*
* *Mechanical difficulties – abilities to feed self.? Dentures*
* *Condition of oral mucous membrane – tongue*
* *Fluid intake (amount; preferred fluids)*
* *Tube feeding, PEG – nasogastric*
* *Nutritional Assessment Score*

**Elimination*** Bladder:
	+ *Voiding pattern nocturia, urgency, frequency, burning,*
	+ *Stream i.e. slow, difficulty in starting*
	+ *Continent/ incontinent*
	+ *Urine amount, colour and characteristics*
	+ *Urinary catheter*
* Bowel:
	+ *Pattern*
	+ *Constipation - diarrhoea*
	+ *Haemorrhoids*
	+ *Continent/ incontinent*
	+ *Stoma –ileostomy – colostomy*
	+ *Bowel Assessment Score (EG Bristol)*

**General Skin Condition:*** Appearance of skin – dry, moist, warm, cold
* Colour of skin – pale –jaundice- dusky - cyanotic
* Evidence of ulcers, old pressure area scars
* Rashes, lesions, excoriation, moles, bruises
* Skin turgor
* Feet /toenails – describe condition
* Oedema
* Skin Assessment Score (EG: Braden, Waterlow)

**Functional Approach****Rest/ Sleep:*** Sleeping pattern – bedtime – rising time
* Afternoon rest/ nap
* Aids to sleep
* Which side does patient get out of bed?

**Pain/ Discomfort:*** Acute
* Chronic
* Location
* Type
* Precipitating factors -what makes pain worse? – what makes pain decrease?
* Pain affecting – sleep – activity – exercises – emotion – concentration – appetite
* Pain Score (EG: 0-10, Wong-Baker, OPQRST

**Mobility*** History of falls
* Potential of falls
* Impaired mobility – poor coordination and balance
* Range of motion in joints – muscular strength
* Weakness
* Supportive devices used e.g. walking aid
* Assistance required to transfer/mobilise
* Falls Risk Assessment Score (EG Hendrich II)

**Activities of Daily Living:*** Functional ability – level of independence with:
	+ Grooming/dressing
	+ Feeding/Toileting
	+ Bathing/Showering
* **Provide details of all assistance required**

**Psychosocial Approach****Emotional*** Any significant concerns, anxieties, grief, loss
* How does the patient feel about himself – observe body language
* Change in role, body image, self esteem
* Ability to cope with stressors
* Depression Score if applicable (EG Geriatric Depression Score)

**Social; Cultural; Spiritual and Relationships*** Previous occupation
* Communication – language/s spoken
* Hobbies, pets
* Cultural considerations, spiritual beliefs, needs
* Dietary practices
* Spouse, partner – caregiver able to assist with care?
* Family – support from family
* Neighbours/ Friends/ Extended family
* Role within family structure
* Church affiliation

**Part B****Plan of Nursing Care****List one health problem or need that your patient/resident has:****Describe two interventions that you used to address the health problem/need.**Intervention 1.Intervention 2.**Describe how you evaluated if your interventions were effective.**Evaluation of Intervention 1:Evaluation of Intervention 2**General Notes** |