

**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** |