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| Graphical user interface  Description automatically generated with low confidence | **Head-to-Toe Assessment and Care Plan**  **Using the Clinical Reasoning Cycle**  **BN602002** | | | (Click [**HERE**](https://www.clinicalkey.com/student/nursing/content/book/3-s2.0-B9780729543378000110?origin=share&title=Jarvis's%20Health%20Assessment%20and%20Physical%20Examination&meta=2021%2C%20Jarvis%2C%20Written%20by%20Carolyn&img=https%3A%2F%2Fcdn.clinicalkey.com%2Fck-thumbnails%2FC20180041924%2Fcov200h.gif)**)** |
| **Ākonga name & ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinical placement location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date and time of assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Safety and environmental risk check:** Professional introductionObtain informed consentPerform hand hygieneEnvironment is conducive for interviewing or performing physical examination (privacy, room temperature, lighting, noise, etc.) | | | Professional interaction throughout (eye contact, body language, appropriate interview questions, situational awareness)Confidentiality- use non-identifiable information in the documentation of assessment findings | |
| **This part of the clinical reasoning cycle involves step 1 (consider the patient situation), step 2 (collect cues/ information), and step 3 (process information).** | | | | |
| **SUBJECTIVE DATA**  (what the person tells you about themselves) | | | | |
| **Reason for Seeking Care**   * *State the patient’s presenting complaint and its history (how did they end up seeking care?).* * *Provide a brief description of the patient’s medical diagnosis/ condition/ surgical procedure. You may add photos, diagrams (pathophysiology) as additional information at the end of the form.* | | | | |
| ***Note:*** *The questions and parameters listed in the left column are designed to guide your data collection process. Feel free to explore and include additional relevant assessment information as appropriate.* | | | | |
| **Health History**   * Biographical data (age, gender, ethnicity, etc.) * Shared goals of care * Health Enduring Power of Attorney (EPOA) * Past health history (chronic conditions, childhood illnesses, injuries, surgeries, immunisations, etc.) * Allergies and sensitivities (include reactions) * Family health history (relevant genetic predispositions; heart diseases; cause of death of blood relatives; etc.) * Lifestyle (Tobacco, alcohol and illicit drugs) * Living environment (safety of the area; hazards) * Occupational health (job title/ satisfaction; hazards) | |  | | |
| **General Overall Health and Wellbeing (based on Te Whare Tapa Wha)** | | | | |
| Taha tinana – physical well-being   * How do you view your situation/ health now? * What are your health goals? * What do you do to keep yourself healthy? * What are your sleeping habits like? | |  | | |
| Taha wairua – spiritual well-being   * Do you identify with any specific cultural/ religious group? * In your culture, are there some health practices that are important to you? * How does your religious faith or spirituality influence the way you think about your health or the way you care for yourself ? | |  | | |
| Taha hinengaro – mental health and emotional well-being   * How would you describe yourself? * What is it about your present situation that is most worrying for you? * Have there been any significant changes in your life in the past year? How do you think this has affected your health? * How do you relieve tension or stress? * How do you keep well? | |  | | |
| Taha whānau – social well-being   * Do you feel comfortable talking about your family? * If you were going to describe your family/whanau, who would they be? * Who are the people that support you (at home/ at a distance)? * Are you currently working? If so, will your workplace support you in your recovery? * What effect will your current illness/hospitalisation have on your relationships and roles? | |  | | |
| **OBJECTIVE DATA**  (Observable, measurable information gathered by the nurse through physical examination, diagnostic tests, or other tools)  ***Note***: *When documenting findings, use precise and accurate terminology (may refer to textbook). Be specific when describing both "normal" and "abnormal" findings (example: instead of stating "normal breath sounds”, provide a detailed description such as "breathing is effortless, regular, and even, with no adventitious sounds like wheezing or crackles."*  Recommended textbook on ClinicalKey (log-in required):  [Jarvis's Health Assessment and Physical Examination](https://www.clinicalkey.com/student/nursing/content/toc/3-s2.0-C20180041924?origin=share&title=Jarvis's%20Health%20Assessment%20and%20Physical%20Examination&meta=2021%2C%20Jarvis%2C%20Carolyn%2C%20PhD%2C%20APRN%2C%20CNP&img=https%3A%2F%2Fcdn.clinicalkey.com%2Fck-thumbnails%2FC20180041924%2Fcov200h.gif) (3rd ed), © 2021  [Lewis’s Medical-Surgical Nursing](https://www.clinicalkey.com/student/nursing/content/toc/3-s2.0-C20210023981?origin=share&title=Lewis%E2%80%99s%20Medical-Surgical%20Nursing%206th%20Australia%20and%20New%20Zealand%20edition&meta=2024%2C%20Brown%2C%20Di%2C%20AO%2C%20RN%2C%20PhD&img=https%3A%2F%2Fcdn.clinicalkey.com%2Fck-thumbnails%2FC20210023981%2Fcov200h.gif) (6th ed) © 2024 | | | | |
| **General Survey**   * Level of consciousness * Skin condition and colour, personal hygiene * Speech – articulation, pattern, content appropriate * Facial Expression * Behaviour Body language, affect * Posture and Gait * Physical Development and body build * Gender and Sexual development | |  | | |
| **Measurement**   * Early Warning Score (EWS), TPR, BP, SPO2 * Weight, Height, BMI * Fluid balance * BGL * Pain assessment (use COLDSPA framework) * Pain reassessment if appropriate | |  | | |
| **Neurological and Musculoskeletal assessment**   * Orientation to time, place, person * Headache, Dizziness * Communication, Behaviour, Speech, Mood * Mobility, motor strength, tremors, weakness, numbness, tingling, coordination * Management of ADL’s * Falls risk assessment tool   If indicated: Glasgow coma scale | |  | | |
| **Respiratory Assessment (ventilation and oxygenation)**   * Respiratory rate, pattern, WOB, symmetry, expansion, accessory muscles * Cough– and deep breathe - any mucous, sputum, secretions * Oxygen therapy (check charting and fitting of mask, nasal prongs)   If indicated Auscultate anterior/posterior lung fields | |  | | |
| **Cardiovascular Assessment/Peripheral vascular (circulation and perfusion)**   * General appearance, skin colour, central cyanosis, temp, moisture * Auscultate rhythm at apex – regular or irregular? * Pulses (radial, dorsalis pedis, posterior tibial, popliteal): regular or irregular? * Any chest pain? * Check capillary refill, clubbing? * Peripheral oedema * Oral or IV fluids * Central or peripheral access, tubing and site dated * Phlebitis score | |  | | |
| **Skin assessment**   * Skin: colour, temperature, turgor * Pressure injury risk * Wounds, drains and invasive sites, last dressed? Dated? Marked? Any signs and symptoms of infection; skin breakdown   If indicated: Use the Braden scale or Waterlow skin risk assessment tool | |  | | |
| **GI and abdominal assessment**   * Appetite, nausea, vomiting, anti-emetics * Dysphagia * Nutrition assessment * Nasogastric tubes, ostomy contents, tube feed if relevant * Bowel pattern, any changes or concerns, Bristol Stool Chart in use? * Abdomen: symmetry, contour, soft or firm, any scars or abnormality. * Enquire if passing flatus, Auscultate bowel sounds if indicated | |  | | |
| **Urinary** **assessment**   * Enquire if voiding regularly * Pain or burning on micturition * IDC insitu? * Check urine: amount and colour, odour | |  | | |
| **Investigations** (blood tests, radiography, other diagnostics) | |  | | |

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| **Current Medications** *(add more rows if required)* | | | | |
| **Medication Name** | **Dosage** | **Route** | **Frequency** | **Indication** |
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| **This part of the clinical reasoning cycle involves step 4 (by identifying problems), step 5 (establishing goals), step 6 (taking action), and step 7 (evaluating outcomes).** |
| 1. Identify **three** nursing diagnosis based on the assessment information you gathered.  * An actual problem should have: **Nursing diagnosis + related factor +defining characteristics** (e.g., Acute pain, related to abdominal surgical wound (colectomy), as evidenced by: Patient verbalising pain; Facial grimacing and body language) * A potential (risk) problem should have: **Nursing diagnosis + related factor** (e.g., Risk for pain related to post-surgical status)  1. Establish a goal: describe what you want to happen, a desired outcome, and a time frame (e.g., At the end of my shift, the patient will identify an acceptable level of pain.) 2. List interventions within your scope. Write the rationale of the chosen intervention including supporting evidence from research to justify its effectiveness and relevance. 3. Evaluate the care plan based on the goal you set (Has the goal been achieved? How did you know it worked? What does a positive outcome look like?)   Useful resources in care planning:  [Lippincott Advisor](https://advisor.lww.com/lna/home.do); [Jarvis's Health Assessment and Physical Examination](https://www.clinicalkey.com/student/nursing/content/toc/3-s2.0-C20180041924?origin=share&title=Jarvis's%20Health%20Assessment%20and%20Physical%20Examination&meta=2021%2C%20Jarvis%2C%20Carolyn%2C%20PhD%2C%20APRN%2C%20CNP&img=https%3A%2F%2Fcdn.clinicalkey.com%2Fck-thumbnails%2FC20180041924%2Fcov200h.gif); [Lewis’s Medical-Surgical Nursing](https://www.clinicalkey.com/student/nursing/content/toc/3-s2.0-C20210023981?origin=share&title=Lewis%E2%80%99s%20Medical-Surgical%20Nursing%206th%20Australia%20and%20New%20Zealand%20edition&meta=2024%2C%20Brown%2C%20Di%2C%20AO%2C%20RN%2C%20PhD&img=https%3A%2F%2Fcdn.clinicalkey.com%2Fck-thumbnails%2FC20210023981%2Fcov200h.gif); [Joanna Briggs Institute Evidence Based Practice](https://ovidsp.dc1.ovid.com/ovid-new-b/ovidweb.cgi?QS2=434f4e1a73d37e8cb17da02d43bbd96c769cedb41845250dd5157a2181ed443b2988f155a87a803f8c750bf3057b589f5b0666a6196b306a4a1e05c6803a92a7072f29835f2e504ab53caf4d59ee88b4464e8a9c7e24e7930070bc3b4b109a9371cc667ff3a676083b85fc0489ca5fd7b983cc391c30e6a5d221dc37b71b1bcb1e11558fd69e727d566fdc7fe0421ea42bb6e232020c0bebc47e4ea953be7c36b8e098d5eb5eea371209eea095b10dfda4494dc3eddf27a2f038a668b46eca81) |

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| **Nursing Diagnosis #1:** | |
| **Goal:** | |
| **Interventions:** | **Rationale:** |
| **Evaluation:** | |

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| **Nursing Diagnosis #2:** | |
| **Goal:** | |
| **Interventions:** | **Rationale:** |
| **Evaluation:** | |

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| **Nursing Diagnosis #3:** | |
| **Goal:** | |
| **Interventions:** | **Rationale:** |
| **Evaluation:** | |

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| **This part of the process involves step 8 (reflection).** |
| **Reflect on process and new learning.**   * Is there anything you would have done differently? * What will you change or continue in your practice moving forward? * What key insights or lessons did you gain from this experience? |
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| **Additional Information (Pathophysiology/ Photos/ Supporting Information)** |
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