

The **THERAPEUTIC**
NURSING PLAN
The track of clinical nursing decisions

APPLICATION OF BILL 90



Ordre
des infirmières
et infirmiers
du Québec

**Document adopted by the Bureau de
l'Ordre des infirmières et infirmiers du Québec
at its April 20 and 21, 2006 meeting**

Coordination and writing

Scientific Department:
Judith Leprohon, R.N., Ph.D.
Louise-Marie Lessard, R.N., Ph.D.

Contributors

OIIQ

Professional Development and Support Department:
Suzanne Durand, R.N.; M.Sc., Nursing; Diplôme d'études
supérieures spécialisées en bioéthique; Director, and her team

External Affairs and Workforce Statistics Department:
Ginette Thériault, M.A., Director,
Carole Mercier, R.N., M.Sc., Jacinthe Normand, R.N., M.P.A. and
Jocelyne Poirier, R.N. M.Ed., Directors

Nursing Practice Supervision Office:
Carole Deshaies, R.N., M.Sc., Director, and her team

Syndic's Office:
Sylvie Truchon, R.N., M.Sc., Director, and her team

Legal Services Department:
Hélène D'Anjou, Legal Counsel

Clinical and teaching community

More than one hundred nurses participated in the creation of this document on the therapeutic nursing plan and a supplemental document to provide support for training and implementation, in which they are identified. These nurses, who come from various regions across Québec, comprise staff nurses from various clinical environments, nursing advisors, nursing managers, directors and nurses in charge of nursing, as well as professors and teachers.

We would like to thank all nurses who contributed directly or indirectly to consultations, examples' production and text validation, over the last three years.

We also wish to thank Anne-Hélène Penault and Suzanne Bélanger for their helpful editing advice.

Production

Customer Services and Communications Department, OIIQ

Coordination

Sylvie Couture, Publications coordinator
Karine Méthot, Assistant

Translation

Lorena Ermacora

Proofreading

Elizabeth McFarlane

Graphic Design

Marc Senécal/Inoxidée

Layout

Béland Design

Distribution

Documentation Centre

Ordre des infirmières et infirmiers du Québec
4200 Dorchester Boulevard West
Montréal, Québec H3Z 1V4
Telephone: 514 935-2501 or 1 800 363-6048
Facsimile: 514 935-5273
cdoc@oiiq.org
www.oiiq.org

Legal Deposit

Bibliothèque et Archives nationales du Québec, 2006
ISBN-10: 2-89229-403-7
ISBN-13: 978-2-89229-403-3

ISBN-10 : 2-89229-407-X (PDF version)
ISBN-13 : 978-2-89229-407-1 (PDF version)

© Ordre des infirmières et infirmiers du Québec, 2006
All rights reserved

Note – In accordance with the OIIQ's editorial policy, the feminine is used only to simplify the text, and designates both men and women.

T A B L E O F C O N T E N T S

THE THERAPEUTIC NURSING PLAN

Introduction	5
Documenting the Therapeutic Nursing Plan: a Professional Standard	5
Documenting the Therapeutic Nursing Plan: Each Nurse's Responsibility	6
Reporting assessment findings: the client's priority problems and needs	6
Accounting for clinical follow-up: nursing directives	7
Supporting clinical decisions	8
Signing the therapeutic nursing plan and its adjustments	8
Recording the therapeutic nursing plan in the client's file, using a separate documentation tool	8
Therapeutic Nursing Plan (TNP)	9
Some Examples	10
1. Long-term care	11
2. Home care	17
3. Surgical care	23
References	26

INTRODUCTION

Bill 90, enacted in January 2003, brought about a new definition of nurses' scope of practice¹ which legally acknowledges their competence and responsibility with regard to clinical assessment. The amendments made to the *Nurses Act* in this regard include three reserved activities and introduce the concept of the "therapeutic nursing plan":

- *Assessing the physical and mental condition of a symptomatic person;*
- *Providing clinical monitoring of the condition of persons whose state of health is problematic, including monitoring and adjusting the **therapeutic nursing plan**;*
- *Providing nursing follow-up for persons with complex health problems.*

These closely interrelated activities are associated with nurses' everyday clinical decisions. However, presently these decisions are either not recorded, or are difficult to locate. Since the nurse is accountable for her clinical decisions, she must record them in the client's file. The therapeutic nursing plan affords easy access to nurses' clinical decisions, made on the basis of her assessment, which are crucial to the clinical follow-up² of the client.

DOCUMENTING THE THERAPEUTIC NURSING PLAN: A PROFESSIONAL STANDARD

In view of the importance of the therapeutic nursing plan for the safety and quality of nursing care, the Bureau of the Ordre des infirmières et infirmiers du Québec has mandated its documentation beginning April 1, 2009, with the adoption of the following standard:

STANDARD

USING A SEPARATE DOCUMENTATION TOOL WITHIN THE CLIENT'S FILE, THE NURSE RECORDS THE THERAPEUTIC NURSING PLAN SHE DETERMINES, ALONG WITH ANY SUBSEQUENT ADJUSTMENTS SHE MAKES BASED ON THE CLIENT'S CLINICAL COURSE AND THE EFFECTIVENESS OF THE CARE AND TREATMENT.

Recorded in the client's file, the therapeutic nursing plan is determined and adjusted by the nurse on the basis of her clinical assessment. It provides an evolving clinical profile of the client's priority problems and needs, and states the nursing directives issued for the client's clinical follow-up, particularly as regards clinical monitoring, care and treatment. The therapeutic nursing plan covers the continuum of care and services and may encompass more than one episode of care.

What is the difference between the therapeutic nursing plan, the nursing care and treatment plan, and the wound care treatment plan?

- The therapeutic nursing plan is a mandatory progress note in the client's file, bringing together nurses' decisions related to the client's clinical follow-up.
- The nursing care and treatment plan is a planning tool which may vary in both form and implementation from one clinical setting to another.
- The wound care treatment plan describes curative or palliative interventions determined by the nurse in order to treat a given wound, and must be recorded in the client's file.

1. In this and subsequent occurrences, the feminine is used without prejudice to streamline the text.

2. Set of interventions determined, implemented and adjusted when needed by the nurse in order to monitor a client's physical and mental condition, to provide him the care and treatment his state of health requires and to evaluate their outcome.

In an interdisciplinary context, the therapeutic nursing plan also provides information on the client's clinical follow-up to be used by the multidisciplinary team when reviewing the interdisciplinary intervention plan³ or the individual service plan.

DOCUMENTING THE THERAPEUTIC NURSING PLAN: EACH NURSE'S RESPONSIBILITY

The nurse must determine a therapeutic nursing plan (TNP) for each client. Exceptions include one-time client interventions (e.g., immunization campaigns or ear irrigations). If it is not the first care episode and the client already has a TNP on file, the nurse must be able to consult this plan to ascertain any elements that may affect the new care episode.

Every nurse who provides care for a client is accountable in regards to the therapeutic nursing plan (TNP). Thus, any nurse, whether or not she has determined the TNP, must apply its directives unless she has to adjust it to take account of changes in the client's condition, the occurrence of new events, the client's reactions or care and treatment outcomes. The nurse must then explain this adjustment in the progress notes or any other permanent nursing documentation tools (clinical pathway, wound care sheet, etc.).

When an expert nurse (in wound care, oncology, lactation, etc.) is involved, she enters her assessment findings in the TNP, along with her follow-up directives. She records their clinical justification in the progress notes.

Depending on the directives it contains, the therapeutic nursing plan (TNP) may concern all members of the nursing team (nurses, nursing assistants and non-professionals). However, only the nurse may determine or adjust the TNP, based on her clinical assessment.

REPORTING ASSESSMENT FINDINGS: THE CLIENT'S PRIORITY PROBLEMS AND NEEDS

The nurse must record in the TNP the client's priority problems and needs determined on the basis of her assessment. These are the findings she deems important for establishing an evolving clinical profile of changes in the client's health situation and for ensuring the necessary clinical follow-up. A problem or need is considered to be a priority if it requires a particular clinical follow-up or will affect the client's clinical follow-up. For instance, a priority may be the presentation of a new problem or need arising during an episode of care, or the deterioration of a previously noted problem.

The clinical findings involve the nurse's judgment and they are based on her analysis and interpretation of the relevant information gathered from various sources. These include data collection tailored to the situation at hand; clinical examination of the client, comprising the client's health history and physical examination; medical diagnoses; diagnostic test results and risk assessment scales, among others. The nurse determines priorities taking into account needs identified in partnership with the client and his significant others, as necessary.

Established in chronological order, the evolving clinical profile shall report the nurse's findings concerning:

- The presence (or onset) and the resolution of the priority problems as well as any change that could impact significantly the client's clinical follow-up;
- The existence (or manifestation) and resolution of priority needs.

3. The interdisciplinary intervention plan contains the interventions planned jointly by members of the multidisciplinary team in response to the client's health care and assistance needs during an episode of intra- and inter-institutional care.

Once the client is discharged after a hospitalization, or following an event of significance to the client's clinical follow-up (a fall or accident, loss of a family member, etc.), the nurse currently taking care of him must re-assess the client's health situation and adjust the TNP as needed.

Assessment findings must be formulated in a short, succinct manner in order to facilitate clinical follow-up. Only problems and risks that will affect the client's clinical follow-up are to be entered in the TNP.

ACCOUNTING FOR CLINICAL FOLLOW-UP: NURSING DIRECTIVES

The nurse must enter her directives for the client's clinical follow-up into the therapeutic nursing plan (TNP) in direct correspondence with the priority problems/needs stated in the TNP. She takes evidence⁴ into account to determine her directives and to adjust them according to changes in the client's health situation and the effectiveness of ongoing care and treatment.

Nursing directives contain crucial indications to ensure that clinical monitoring, nursing care, treatment and other interventions the client requires are carried out. These directives usually involve specific or exceptional indications. They concern particular interventions required by the client's health situation or atypical changes in his condition. In the case of pain relief, for example, verification of analgesic effectiveness following administration is a standard of practice and does not need to be specified in the TNP unless this verification aims at allowing the nurse to make dose adjustments that are required for relief of breakthrough pain.

Nursing directives on clinical monitoring are an important part of clinical follow-up. They help nurses to:

- Determine and adjust clinical monitoring targets and parameters in accordance with changes in the client's clinical condition;
- Involve other nursing team members by indicating what signs and symptoms should be observed and reported to the nurse.

As part of the clinical follow-up of her client, the nurse also gives directives concerning certain prescribed medical care and treatment. For example, she could give directives to:

- Carry out medical treatment in accordance with a collective prescription (e.g., administering an enema);
- Specify an intervention strategy (e.g., rectal administration of analgesic to a nauseous client).

The degree of specificity of the nursing directives will vary, depending on the documentation and clinical tools used. The directives will be less precise, for example, if standardized nursing care and treatment plans or clinical pathways (case management) are used, except for client-specific adjustments (see example 3).

In formulating her directives, the nurse also takes into account the people likely to participate in carrying out the therapeutic nursing plan (TNP), i.e., nursing assistants, non-professionals (orderlies, home care workers, etc.), clients and their significant others.

In the spirit of interprofessional collaboration, the nurse can specify conditions to be carried out in order to maximize the contribution of **nursing assistants** in carrying out the TNP.

4. Recognized practices based notably on research findings or expert consensus, for example.

Such conditions may be used notably to:

- Specify the signs and symptoms that may require intervention according to changes in the client's clinical condition (e.g., "IF no stool for three days, apply nursing protocol for constipation");
- Indicate the situations in which the nursing assistant should notify the nurse so that the latter may perform a clinical assessment (e.g., if administration of a glycerin suppository has not been effective; or BEFORE administering a PRN analgesic to a client whose pain she is trying to control using breakthrough doses).

When working with nursing assistants, the nurse must specify in her directives the activities to be carried out by a nurse. These include the activities pertaining to her field of practice (e.g., "nurse to assess wound q week") as well as those she deems essential to do herself in view of the client's condition or the complexity of the nursing care or treatment involved (e.g., "nurse to change four-layer compression bandage q week").

When issuing directives to non-professionals, the nurse takes into account the fact that they don't have access to the client's file. Therefore, she indicates in the TNP what these directives are about, and how they will be transmitted (e.g., Dir. orderlies' work plan vs. report agitated behaviour). When transmitting TNP directives to non-professionals, the nurse ensures that they are sufficiently explicit so that adequate follow-up is possible (e.g., listing in the orderlies' work plan the signs and symptoms to observe and report). The same applies when giving directives to **clients or their significant others**.

SUPPORTING CLINICAL DECISIONS

The nurse must support the contents of the therapeutic nursing plan and any adjustments she makes in the client's progress notes or other permanent nursing document.

Progress notes should focus on the nurse's clinical decisions. Whether these decisions pertain to her clinical assessment or the client's clinical follow-up, she provides clinical justification in reference to the client's evolving condition. She bases her decisions on available evidence, when appropriate.

SIGNING THE THERAPEUTIC NURSING PLAN AND ITS ADJUSTMENTS

In view of her professional liability, the nurse must sign the TNP she has determined, including any adjustments. She also signs the directives from the TNP transmitted in writing to the non-professional staff or to the client and his significant others.

RECORDING THE THERAPEUTIC NURSING PLAN IN THE CLIENT'S FILE, USING A SEPARATE DOCUMENTATION TOOL

The therapeutic nursing plan is part of the client's file and is recorded using a separate documentation tool. It pertains only to the priority health problems and needs that affect the client's clinical follow-up and nursing directives crucial to this follow-up. Thus, the TNP provides an easily accessible summary of the nurse's decisions concerning the client's clinical follow-up. For example, the TNP could cover a short-term care period of three days or a long-term care period of three months on a single page.

The form provided on the next page is designed to help in applying the standard for documenting the TNP. The priority aspect of the information it contains should limit duplications in its content and that of other documentation tools in use (nursing care and treatment plan, clinical pathway, flowsheets, etc.). Different ways of making the TNP available, whether throughout the entire continuum of care and services or from one episode of care to another, should be examined.

SOME EXAMPLES

To illustrate the use of the therapeutic nursing plan, here are three examples taken from different contexts of practice.

Examples

1. Long-term care – Pain relief
2. Community health – Home care
3. Surgical care

Illustrations

- CHSLD – Nursing team
CSSS – CLSC – Continuum of care and services
CSSS – HC – Case management

These examples were developed in cooperation with nurses from various workplaces and adapted for use in the present document.⁵

Each of the following examples contains a brief summary of the clinical situation, the therapeutic nursing plan, extracts from progress notes and explanatory comments that highlight the various factors to consider when determining and adjusting a therapeutic nursing plan. *In these examples, problems have been colour-coded to refer more easily to corresponding nursing directives, progress note abstracts and comments.*

5. The full versions of the three examples, along with other examples, are found in *L'intégration du plan thérapeutique infirmier à la pratique clinique – Document de soutien à la formation et à l'implantation* (OIIQ, 2006).

1 EXAMPLE 1 LONG-TERM CARE

Contributed by: Monique Bourque, R.N., M.A., Institut universitaire de gériatrie de Sherbrooke
Linda Thibault, R.N., M.Sc., Institut universitaire de gériatrie de Montréal

This example covers a period of about three months, from October 16, 2005 to January 21, 2006, and involves a clinical situation occurring in a long-term care unit. The nursing team consists of a nurse, nursing assistants who provide the care for the most part and administer medication, and orderlies who provide assistance with activities of daily living, such as hygiene and elimination.

Summary of clinical situation

- Mrs. Alice Beaugard, 89 years old, presents with severe cognitive impairment due to Alzheimer's disease, assessed at stage VI-VII, and consequently considerable loss of autonomy in all activities of daily living (ADL).
- She also has severe arthrosis and osteoporosis.
- Mrs. Beaugard is taking the following medication:
 - Acetaminophen (Tylenol) 325 mg 2 tablets PO qid;
 - Codeine 15 mg 1 tablet PO every 3–4 h PRN;
 - Risperidone (Risperdal) .25 mg 1 tablet PO tid;
 - Sennoside (Senokot) 2 tablets PO q.d.;
 - Docusate (Colace) 1 tablet PO q.d.
- For some time, during re-positioning and hygiene care, she has become agitated, verbally abusive (screaming, whining and insulting) and physically aggressive (hitting, pinching and scratching).
- At the beginning of the period described, a clinical follow-up of her agitated and aggressive behaviour quickly led the nurse to establish a link with pain, while considering the possibility that other factors might also be involved.
- The nurse determines a pain intervention strategy which consists of regular administration of PRN codeine to decrease pain on re-positioning. One week later, Codeine is discontinued, and replaced by Fentanyl (Duragesic).
- Mrs. Beaugard subsequently presents with a Stage 1 wound and constipation despite the preventive measures implemented. Considering the use of night-time protective underwear to decrease painful manipulation, her reduced mobility and other factors contributing to the fragility of her skin, the nurse assesses a risk of impaired skin integrity which requires clinical follow-up.

**EXTRACT: PERIOD COVERING
OCTOBER 16, 2005 TO JANUARY 21, 2006 (3 MONTHS)**

EXAMPLE 1

THERAPEUTIC NURSING PLAN (TNP)

MRS. BEAUREGARD

ASSESSMENT FINDINGS								
Date	Time	No.	Priority Problem or Need	Initials	RESOLVED / SATISFIED			Professional/ Department Involved
					Date	Time	Initials	
2000-11-17		1	Loss of autonomy R/T cognitive impairment (Alzheimer)	—				Multidisc. team
2005-10-16	9:30	2	Agitation and aggressive behaviours	MB				
	14:30	3	Chronic pain related to positioning					MD, Physio
		4	Risk of constipation	MB				
2005-10-27	10:00	5	Risk of impaired skin integrity (coccyx)	MB				OT, dietician

CLINICAL FOLLOW-UP							
Date	Time	No.	Nursing Directive	Initials	DISCONTINUED/ CARRIED OUT		
					Date	Time	Initials
2005-10-16	9:30	2	Give hygiene and incontinence care with 2 caregivers at a time along with diversion tactics (+ dir. orderlies' work plan) [A]	MB			
	14:30	3	Administer Codeine 15 mg 30 to 60 min. before hygiene care and before bedtime concurrently with Tylenol [F]		2005-10-23	10:00	MB
			Dir. orderlies' work plan: Notify nurse or nursing assistant of any sign of pain [G]				
			Notify nurse if Codeine ineffective [H]				
			Nurse to assess with Doloplus 2 on 2005-10-23 [I]		2005-10-23	10:00	MB
		4	If no stool X 3 days, administer glycerin supp. IR; repeat after 30 min.; if no result after 3 hrs, notify nurse [J]				
			Notify nurse if glycerin supp. given > 1 / week [K]	MB	2005-10-27	10:00	MB
2005-10-23	10:00	2	Fill out clinical observation scale X 3 days (+ dir. orderlies' work plan) [B]		2005-10-27	10:00	MB
		2 3	Nurse to assess pain + agitation and aggressive behaviours 2005-10-27 [D]	MB	2005-10-27	10:00	MB
2005-10-27	10:00	2	Check if basic and safety needs are met before q care (+ dir. orderlies' work plan) [C]				
		2 3	Nurse to re-assess pain + agitation and aggressive behaviours q Tuesday [E]				
		2 5	Notify nurse if buttock redness + agitation (+ dir. orderlies' work plan) [L]	MB			

Signature of Nurse	Initials	Program/Dept.	Signature of Nurse	Initials	Program/Dept.
Madeleine Bastien	MB	2 nd O			

EXAMPLE 1 (Cont'd)

THERAPEUTIC NURSING PLAN (TNP)

MRS. BEAUREGARD

ASSESSMENT FINDINGS								
Date	Time	No.	Priority Problem or Need	Initials	RESOLVED / SATISFIED			Professional/ Department Involved
					Date	Time	Initials	
2006-01-10	8:30	6	Stage I wound: reddened coccyx area	KV	2006-01-21	13:30	KV	

CLINICAL FOLLOW-UP								
Date	Time	No.	Nursing Directive	Initials	DISCONTINUED/ CARRIED OUT			
					Date	Time	Initials	
2006-01-10	8:30	6	Treatment plan: wash buttock area with surfactant + apply barrier cream					
			with each protective underwear change (+ dir. orderlies' work plan) [M]		2006-01-21	13:30	KV	
			Dir. orderlies' work plan: reposition q h [N]					
			Notify nurse of any signs of deterioration: exudate, pink or red skin, erosion		2006-01-21	13:30	KV	
			(+ dir. orderlies' work plan) [O]					
			Nurse to assess wound Tuesday [P]	KV	2006-01-21	13:30	KV	

Signature of Nurse	Initials	Program/Dept.	Signature of Nurse	Initials	Program/Dept.
Karine Vanier	KV	2 nd O			

Comments

- 1 • 2000-11-17: Priority problem which does not require specific follow-up at the present time but will affect Mrs. Beaugard's clinical follow-up.
- 2 • 2005-10-16 (9:30): Priority problem identified by the nurse following her assessment of Mrs. Beaugard's physical and mental condition, based notably on a clinical examination and the behaviours noted by the nursing team, as well as the nurse's own observations.
• 2005-10-23 (9:30): Problem improvement following pain control (documented in progress notes).
- 3 • 2005-10-16 (14:30): Finding justified in progress notes, notably by a 8/30 score on the Doloplus 2⁶ scale, confirming pain unresolved by current medication and explaining in part Mrs. Beaugard's aggressive behaviour.
• Indication concerning physician and physiotherapist intervention for this problem.
- 4 • 2005-10-23 (14:30): Potential priority problem resulting from a combination of several factors, including the use of narcotic analgesics to alleviate pain.
- 5 • 2005-10-27 (10:00): Potential priority problem related to regular use of incontinence underwear to reduce frequency of re-positioning and other factors such as reduced mobility and activity level.
• Indication concerning intervention of occupational therapist and dietician of the multidisciplinary team to reduce the impact of contributing factors.
- 6 • 2006-01-10 (8:30): Priority problem for which the nurse reviewed associated factors with the nursing team and determined the required treatment plan. Problem resolved on 2006-01-21. However, since these factors are still present, the risk of impaired skin integrity (problem #5) persists.

- 1 • Interventions related to this problem consist mainly of assisting Mrs. Beaugard in her activities of daily living (ADL) which are determined in the nursing care and treatment plan.
- 2 • 2005-10-16 (9:30): **[A]** Nursing directive concerning an intervention strategy to be applied by all members of the nursing team.
• 2005-10-23 (10:00) **[B]** Nursing directive to fill out behaviour observation scale to document aggressive behaviour and agitation, triggering factors, and helpful and non-helpful interventions, and transmission through their work plan.
• 2005-10-27 (10:00): **[C]** Analysis of the scale as documented in the progress notes allows the nurse to determine an intervention strategy for the nursing team which she describes in the orderlies' work plan.
- 2 3 • 2005-10-23 (10:00): Nursing directive for the nurse to assess pain control and residual agitation and aggressive behaviours, once the behaviour observation scale has been completed on the 27th **[D]** and every week thereafter **[E]**.
- 3 • 2005-10-16: **[F]** Nursing directive to nurses and nursing assistants to apply an intervention strategy intended to maximize the effectiveness of the medication. Besides this indication, the nursing assistant administers Codeine PRN when needed. The strategy is discontinued when Duragesic[®] is ordered by her physician (2005-10-23).
• 2005-10-16: **[G]** Nursing directive to orderlies to notify the nurse or the nursing assistant so that Mrs. Beaugard can obtain an analgesic to relieve her pain.
• 2005-10-16: **[H]** Nursing directive requiring the collaboration of nursing assistants in order to determine the effectiveness of pain control.
• 2005-10-16 (14:30): **[I]** Nursing directive indicating the next assessment to be done by the nurse using Doloplus 2.
- 4 • 2005-10-16 (14:30): **[J]** Nursing directive to nursing assistants concerning the relief of constipation when needed.
• Measures to prevent constipation are determined in the nursing care and treatment plan.
• **[K]** Nursing directive requiring nursing assistants' collaboration in the clinical monitoring of Mrs. Beaugard's risk of constipation.
- 2 5 • 2005-10-27: **[L]** Nursing directives to involve nursing assistants and orderlies in monitoring Mrs. Beaugard's skin integrity as well as agitation and aggressive behaviours.
• Measures to maintain skin integrity are explicitly detailed in the nursing care and treatment plan.
- 6 • 2006-01-10: **[M]** Wound treatment plan to be carried out by nursing team, with more precise instructions written in the orderlies' work plan.
• 2006-01-10: **[N]** Nursing directive to increase the frequency of re-positioning.
• 2006-01-10: **[O]** Nursing directive to nursing assistants and orderlies concerning their contribution to the monitoring of the wound.
• 2006-01-10: **[P]** Nursing directive indicating the frequency of wound care assessment by the nurse (every week). Directive discontinued on resolution of the problem on the 21st.

Progress Notes (Extracts)

2005-10-12

9:30: Tries to hit and screams when lifted. Difficult to give hygiene care: resists and seems in pain. Codeine 15 mg PO 1 tab. given.
10:15: Seems relieved. Doesn't scream but pushes back caregivers when put in her chair. Brigitte Durand, RNA

2005-10-14

20:00: Screams +++, seems in pain, becomes easily irritable when put to bed. Codeine 15 mg PO 1 tab. given.
21:45: Is sleeping. Nicole Filteau, RNA

2005-10-16

2

9:30: Agitation and aggressive behaviour (scratching, hitting, yelling) during hygiene care and re-positioning for the past week, demonstrates signs of pain such as facial contortions, complaints, grimacing. Codeine 15 mg seems to reduce agitation and aggressive behaviour. Is not constipated.

3

14:30: Past history compatible with pain. Assessment with Doloplus 2 score at 8/30 confirming presence of pain. Madeleine Bastien, RN.

2005-10-23

3

9:50: Reassessed with Doloplus 2: score at 4. Pain relieved with administration of Codeine before re-positioning.

2

Residual agitation and aggressive behaviour during hygiene care and re-positioning, of lesser intensity since administration of Codeine before hygiene care and re-positioning. Fill out clinical observation scale for 3 days. Madeleine Bastien, RN.

2005-10-27

2

3

10:00: Analysis of clinical observation scale: agitation, verbal and physical aggressive behaviour related to re-positioning (protective underwear change, hygiene care, placing in bed) and basic (hunger, thirst, elimination) and safety needs (fear during bath). Monitor q week and directives to orderlies.

5

Addition of incontinence protective underwear increases risk of skin lesions, Braden scale score: 13. Monitor skin integrity and nursing directives to orderlies re prevention measures. Madeleine Bastien, RN.



EXAMPLE 2 HOME CARE

Contributed by: Sylvie Lafrenière, R.N., M.Sc., CLSC Montréal-Nord⁷
Esther Gaudreau, R.N., B.Sc., CLSC Hochelaga-Maisonneuve

This example describes a clinical situation involving two missions of a Health and Social Services Centre (CSSS). A client has been referred by the hospital to the CLSC's community service program for age-related loss of autonomy (PALV). The extract from the therapeutic nursing plan covers the three-month period after his discharge from the hospital.

Summary of clinical situation

- Mr. Bernard Dionne, 72 years old, has been widowed for one year and lives alone.
- He has Type 2 diabetes, diagnosed seven years previously.
- He was referred to the program because of a diabetic ulcer.
- He also presents with heart failure, which explains his growing activity intolerance and difficulty leaving the house.

Upon his discharge from the hospital, three unresolved priority problems are listed in the therapeutic nursing plan and taken into account by the CLSC nurse in the clinical follow-up: (1) deep diabetic ulcer on the sole of his left foot (Grade IIA, Wagner classification) with neuropathy; (2) risk of heart failure deterioration and (3) poorly controlled diabetes related to non-compliance with therapeutic regimen.

The additional information gathered by the program nurse during her visits and communications with Mr. Dionne's daughter revealed the following:

- Mr. Dionne is poorly motivated in his personal hygiene and nutrition.
- His only daughter says she is discouraged to see her father neglecting himself, eating poorly and little, and forgetting to take his medication. Their relationship is strained because her father believes she would like the nurse to convince him to be placed in a home against his will.
- Before his hospitalization, he used to tinker around and do odd jobs for other tenants in the building, but now feels unable to carry on these activities because he tires easily.
- He feels overwhelmed and helpless, and cries when alluding to his wife's death, saying he is good for nothing.
- The nurse notes that he feels sad, has lost interest in his usual activities, and has insomnia. He says he has been experiencing memory loss for some time. His score on the geriatric depression scale is 25/30 (Brink and Yesavage, 1982) and 29/30 on the MMSE (Folstein).
- He has been taking 2 to 5 1 mg Ativan tablets per day since the death of his spouse. His daughter has found him on the floor twice since his release from the hospital.

7. Employer at the time the case was written.

**EXTRACT: PERIOD COVERING
MAY 20 TO AUGUST 30, 2005 (3 MONTHS)**

EXAMPLE 2

THERAPEUTIC NURSING PLAN (TNP)

MR. BERNARD DIONNE

ASSESSMENT FINDINGS									
Date	Time	No.	Priority Problem or Need	Initials	RESOLVED / SATISFIED			Professional/ Department Involved	
					Date	Time	Initials		
2005-05-20	11:00	1	Grade IIA diabetic ulcer: sole left foot	FM				MD	
2005-05-28	9:30	2	Risk of deterioration: cardiac failure	FM				MD, Info-Santé	
		3	Poorly controlled diabetes related to non-compliance with therapeutic regimen	FM	2005-08-30	9:30	GN	MD, Info-Santé, dietician	
2005-05-30	10:30	4	Personal neglect: hygiene, diet, self-care	GN	2005-08-30	9:30	GN	HC worker	
2005-06-06	11:30	5	Strained relations with only daughter	GN				Social worker	
2005-06-14	14:00	6	Depressive state	GN				MD, HC worker, Day centre	
CLINICAL FOLLOW-UP									
Date	Time	No.	Nursing Directive	Initials	DISCONTINUED/ CARRIED OUT				
					Date	Time	Initials		
2005-05-20	11:00	1	Apply wound treatment plan q 2 days; q 3 days if primary dressing not saturated [A]	FM					
2005-05-28	9:30	2	Monitor VS, edema, breath sounds, activity intol., weight q 2 wks. [C]		2005-06-14	14:00	GN		
		3	Consolidate learning on self-care prior to hospital discharge [F]		2005-08-30	9:30	GN		
			Monitor capillary blood glucose 3 times/wk. X 3 weeks [G]		2005-06-14	14:00	GN		
			Monitor Hb A _{1c} values q 3 months [H]	FM					
2005-05-30	10:30	2	Teach self-monitoring re cardiac failure [E]						
		3	Use monofilament test re compliance with treatment [I]						
		2 3	Register with Info-Santé [L]	GN	2005-08-30	10:30	GN		
2005-06-01	11:45	2 3 4	Dir. to H.C. worker's work plan						
			• notify nurse if signs of APE, ☉ med. intake, sleepiness [M]						
			• diet, hygiene, autonomy, weight [N]	GN					
2005-06-14	14:00	1	Replace alginate with aqueous gel [B]						
		2	Monitor VS, edema, breath sounds, activity intol., weight q month [D]						
		3	Nurse to monitor glycemia q wk. [J]						
		6	Verbal dir. to client: consult MD [P]	GN	2005-06-20	14:00	GN		
			Assess depressive status q wk. [Q]		2005-08-30	9:30	GN		
Signature of Nurse			Initials	Program/Dept.	Signature of Nurse			Initials	Program/Dept.
France Marsolais			FM	CSSS- HC 5 th South					
Gabriel Nolin			GN	CSSS-CLSC/PALV					

Comments

1 2 3

- Unresolved priority problems upon hospital discharge requiring clinical follow-up by CLSC nurse. They are also being followed up by his physician.

2 3

- Info-Santé involved upon Mr. Dionne's registration by CLSC nurse on 2005-05-30.

4 to 8

- Priority problems determined by CLSC nurse based on her clinical assessment of Mr. Dionne.

3

- 2005-05-28: Assessment finding supported in progress notes where it is stated that glycated hemoglobin is 10%, indicating non-compliance with treatment.
- Indication concerning dietician intervention as planned in interdisciplinary intervention plan developed by CLSC.
- 2005-08-30: Resolution assessed by CLSC nurse further to improvement in Mr. Dionne's mental status.

4

- 2005-05-30: Priority problem requiring clinical follow-up by nurse and participation of home care (HC) worker. Problem resolved 2005-08-30 further to improvement in mental condition and reduction of Ativan intake.

5

- 2005-06-06: Assessment finding determined after discussion with Mr. Dionne's daughter and supported in progress notes.
- Indication that social worker is involved further to Mr. Dionne's approval and referral by the nurse (2005-08-30).

6

- 2005-06-14: Determined after a mental health assessment. This finding is documented in progress notes: feelings of helplessness and sadness added to self-neglect, leading to finding of depressive state. Unresolved grief and Ativan intake may also have synergic effect.

7

- 2005-06-14: Assessment finding following analysis of various data collected from client, his daughter and home care worker over the past two weeks.

8

- 2005-06-14: Priority problem with impact on several other problems presented by Mr. Dionne and requiring follow-up. Resolution of problem noted on 2005-08-30.

1

- 2005-05-20: **[A]** Indication concerning wound treatment plan and frequency of dressing changes as determined by hospital nurse. Since client's file contains wound care flow sheet, treatment plan is described there in addition to subsequent adjustments.
- 2005-06-14: **[B]** Indication concerning adjustment to treatment explained by clinical changes in wound condition.

2

- 2005-05-28: **[C]** Frequency of clinical monitoring (q 2 weeks) determined by hospital nurse at discharge and **[D]** adjusted (q wk.) by CLSC nurse on 2005-06-14 in view of changes in client's clinical condition.
- 2005-05-30: **[E]** Nursing directives to client re self-monitoring of signs of deterioration.

3

- 2005-05-28: **[F]** Consolidation of learning on self-care not completed at discharge due to poor client readiness.
- **[G] [H]** Hospital nurse's directives concerning clinical monitoring frequency of capillary blood glucose and glycosylated hemoglobin.
- 2005-05-30: **[I]** Indication concerning the use by the nurse of monofilament to foster awareness of neuropathy, and consequently, compliance with therapeutic regimen.
- 2005-06-14: **[J]** Adjustment of glycemia monitoring frequency due to glycemic stabilization.
- 2005-08-30: **[K]** Nursing directive to the client to keep a journal to monitor blood glucose now that he is ready.

2 3

- 2005-05-30: **[L]** Registration with Info-Santé secondary to the risk of decompensation, the loss of autonomy and his difficulty in clearly explaining his health situation. Discontinued further to improvement of physical and mental condition.

2 3 4

- 2005-06-01: Nursing directives to home care worker concerning the signs to observe and to report to the nurse **[M]** as well as encouragement re hygiene, meal preparation, activity, etc. **[N]**.

5 7

- 2005-08-30: **[O]** Upon noting strained relationship between father and daughter, the CLSC nurse initially tried to begin a dialogue as part of her clinical follow-up, then to refer Mr. Dionne to the social worker, which he had refused to this date.

6

- 2005-06-14: **[P]** Verbal nursing directive to consult MD for depressive state. Indication that the directive has been carried out.
- 2005-06-14: **[Q]** Nursing directive focussing on the monitoring of the client's depressive state.
- 2005-06-14: **[R]** Nursing directive to home care worker re encouraging client autonomy, e.g., adopting non-controlling approach to help reduce feeling of helplessness.
- 2005-06-20: **[S]** Indication concerning clinical monitoring re antidepressant intake, with help from home care worker.
- 2005-07-15: **[T]** Reduction in the frequency of home care visits [2 visits 1 1/2 h/ week → 1 2 h-visit / wk.] following agreement with Mr. Dionne, who feels overwhelmed and wants greater control over daily activities.
- 2005-08-30: **[U]** Reduction in assessment frequency [q wk. → q 2 wk.] to take into account improvement in mental condition, and justification in the progress notes.

6 7

- 2005-06-14: **[V]** Nursing directive for weekly cognitive and behavioural interventions.

8

- 2005-06-14: **[W]** Indication concerning monitoring of Ativan intake and verbal directive to client to keep a journal to record his Ativan intake.

Progress Notes (Extracts)

2005-06-06

5

14:30: Telephone conversation with only daughter who visits once a week to run errands and do grocery shopping, laundry and cleaning. Says she is discouraged to see her father let himself go, have a poor diet and eat so little. Has found him on the floor twice since the death of her mother. Insists on monitoring him, especially his banking, because he forgets to pay his bills. Feels he is no longer the same person and wishes he would take himself in hand. Gabriel Nolin, R.N.

2005-06-14

2

15:45: Weight: 67 kg Lungs: clear with normal BS. No palpebral edema upon waking; no edema in lower limbs.

BP 144/88; HR 88 regular; RR 20 regular. Shortness of breath decreased since pre-hospitalization; no energy to carry out usual activities. Takes medications as prescribed; reports spending a lot of time in bathroom and considers it a nuisance.

3

Blood glucose between 8 and 15 mmol/L a.c. For the moment, refuses to consider controlling it on his own. Monitor q wk.

5

Continued strained relations with daughter, who wants to begin visiting nursing homes; her phone calls upset him. Still won't see social worker.

6 7 8

Sad mood, no appetite at meals, says he feels helpless about life in general, takes between 2 and 5 tablets Ativan per day, including 2 at bedtime. Score on geriatric depression scale: 25/30. No suicidal thoughts. MMSE (Folstein) 29/30. Agrees to make a medical appointment for depression symptoms and undesirable medication effects. "Finds it difficult to live alone without his spouse; cannot adapt to her absence; unable to find interest in life." Gabriel Nolin, R.N.

2005-07-15

4 6

11:30: Heats up frozen dinners on his own and prepares simple meals. "Fed up" with having people in the house. Agreement: reduce number of home care worker hours to 2 hrs /wk. Gabriel Nolin, R.N.

2005-08-30

3

12:30: Agrees to meet with dietician. Follows diet more closely. Hb A_{1c} at 8.8% at last test. Agrees to check his glucose and note results.

5 7

In spite of her efforts to the contrary, daughter still averse to letting father make decisions, which, in her opinion, are not in his best interest. Fears relapse. Housing and financial aspects at centre of conflict. Client agrees to see social worker to discuss major long-standing conflicts with daughter. Also agrees to talk about spouse's death.

6 8

Improvement in mood and energy level. Depression scale at 15/30; started attending day centre, takes 1 dose Ativan HS 3 times/wk. Gabriel Nolin, R.N.

3

EXAMPLE 3 SURGICAL CARE

Contributed by: Anne Legendre-Parent, R.N., M.Sc., Centre hospitalier universitaire de Québec
Nicole Cyr, R.N., M.Sc., Centre hospitalier de l'Université de Montréal

This example involves part of an episode of care for a knee arthroplasty in an orthopedic surgical unit that uses clinical pathways⁸ as part of its case management approach. The nursing team is composed of nurses and orderlies previously trained to follow a pre-established plan for activities related to re-positioning and hygiene care. The expected length of stay for this clientele varies from five to seven days. The episode described in this example is the second day of post-operative care.

Summary of clinical situation

- Mrs. Côté, age 78, presents with arthrosis in the right knee, requiring arthroplasty. She does not use walking aids despite the pain she experiences when moving.
- Four weeks before her operation, Mrs. Côté received preparatory care for the surgery at the ambulatory care unit. She was given an information and teaching guide entitled *Knee Surgery*. In accordance with the interdisciplinary intervention plan, the physiotherapist, the occupational therapist and the anesthesiologist also met with her.
- During the initial assessment, Mrs. Côté said she was in good health despite some chronic medical problems that are being controlled with medication – hypertension and high cholesterol, which have been treated for the past two years.
- Following surgery two years ago, she was delirious for almost 48 hours.
- She lives with her spouse, who can help her return home. She drives a car and is able to carry out activities of daily living (laundry, cleaning and groceries).
- The CSSS-CLSC will be involved by providing physiotherapy, removing staples and following up on anticoagulation therapy.
- Mrs. Côté was admitted to the hospital centre on the morning of the surgery. According to the information in the clinical pathway for the day of the operation and the following day, Mrs. Côté's clinical course is as foreseen.
- On the second day after the operation, she presents with a reddened heel, elevated temperature and intense pain during physiotherapy uncontrolled by the analgesics normally prescribed for that particular postoperative phase.

8. The clinical pathway for total arthroplasty covers the period from pre-admission to the planned discharge. It is developed by a multidisciplinary team based on expected outcomes throughout the care period. The clinical pathway includes a section reserved for nursing care in which clinical follow-up, care and treatment are pre-established according to normal postoperative changes and the most frequently observed problems. Therefore, it serves as a nursing care and treatment plan and also takes account of the clinical follow-up carried out for problems occurring after this type of surgery, describing the care and treatment to be provided as well as observed outcomes. In addition, a space is provided for complementary progress notes where appropriate.

Comments

- | | |
|---|---|
| 1 | <ul style="list-style-type: none"> • 2005-08-02: Arthroplasty is the reason for Mrs. Côté's hospitalization. The nurse enters this surgical treatment in the TNP as a priority need to ensure the necessary clinical follow-up. • The therapeutic nursing plan for a post-operative patient who would not present any problems other than those expected in the case management clinical pathway of the patient tracking system would only include this statement under the <i>Assessment Findings</i> section. |
| 2 | <ul style="list-style-type: none"> • 2005-08-02: Potential problem identified during initial pre-admission assessment and requiring special follow-up since this problem is specific to Mrs. Côté. |
| 3 | <ul style="list-style-type: none"> • 2005-08-04: Priority problem requiring specific clinical follow-up. • Indication concerning the occupational therapist's intervention in connection with this problem. |
| 4 | <ul style="list-style-type: none"> • 2005-08-04: Priority problem not expected in the normal postoperative clinical course and requiring closer clinical monitoring. |
| 5 | <ul style="list-style-type: none"> • 2005-08-04: Although pain is a normal part of postoperative clinical course, the nurse considers that the intensity experienced by Mrs. Côté at this point in the episode of care is greater and requires special clinical follow-up, thus its inclusion in the TNP. |
-
- | | |
|---|--|
| 1 | <ul style="list-style-type: none"> • 2005-08-02: [A] Reference to clinical pathway indicates that it contains the standard interventions pre-determined for this clientele. |
| 2 | <ul style="list-style-type: none"> • 2005-08-02: [B, C] Nursing directives to orderlies concerning signs to report to the nurse for clinical monitoring purposes and how to intervene if Mrs. Côté presents with signs of delirium. • If Mrs. Côté presented with signs of delirium, the nurse would adjust the therapeutic nursing plan accordingly, justifying the changes by describing client's behaviour in the complementary notes in the clinical pathway. |
| 3 | <ul style="list-style-type: none"> • 2005-08-04: [D] Nursing directive to re-position more often than planned in clinical pathway (q 4 h → q 2 h) with specific instructions to orderlies to this effect transmitted in their work plan. This indication in the TNP is justified in the complementary notes of the clinical pathway. |
| 4 | <ul style="list-style-type: none"> • 2005-08-04: [E] Nursing directive to take temperature more often than established in clinical pathway (bid → q 4 h). Monitoring of signs of infection and encouragement of respiratory exercises are already planned in clinical pathway. |
| 5 | <ul style="list-style-type: none"> • 2005-08-04: [F] Intervention strategy indicating use of narcotic analgesic and time when medication should be administered to relieve Mrs. Côté when she exercises or is moved. Nurse writes clinical data justifying this adjustment in the clinical pathway's complementary notes. |

Complementary Notes (Clinical Pathway)

2005-08-04

- | | |
|---|---|
| 4 | <p>13:00: T° 38.6. Diaphoresis. No chills. No redness knee wound, slight leak at drain site. No calf pain, Homans' sign negative; voids without difficulty. Lungs clear. Plan: Tylenol, encourage respiratory exercises and movement, monitor T° q 4 h. Chantal Boisvert, R.N.</p> <p>17:00 T° 37.6.</p> |
| 5 | <p>19:00: Ineffective pain control medial R knee in the form of stabbing pain, at 8/10. ↑ since flexibility exercises. Tylenol 650 mg PO and ice x 12 min. Re-positioned.</p> <p>20:00: Pain R knee, relieved at 4/10 by Tylenol. Plan: Change to narcotic analgesic: Dilaudid 2 mg PO 30 min. before exercises. Claude Vinet, R.N.</p> |

REFERENCES

DIONNE, S. and J. BOULAY. *Guide bilingue des abréviations médicales/Bilingual Guide to Medical Abbreviations*. (3rd ed.), Montréal, Maclean Hunter Santé, 1998.

An Act to amend the Professional Code and other legislative provisions as regards the health sector, S.Q. 2002, c. 33.

Nurses Act, R.S.Q., c. I-8.

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *Le suivi systématique de clientèles : une solution infirmière*, Montréal, OIIQ, 1996.

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *Le suivi systématique de clientèles dans la communauté*, Montréal, OIIQ, 1999.

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *Énoncé de principes sur la documentation des soins infirmiers*, Montréal, OIIQ, 2002.

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *L'exercice infirmier en santé communautaire : soutien à domicile*, Montréal, OIIQ, 2003, coll. « Lignes directrices ».

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *Guide d'application de la nouvelle Loi sur les infirmières et les infirmiers et de la Loi modifiant le Code des professions et d'autres dispositions législatives dans le domaine de la santé*, Montréal, OIIQ, 2003.

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *Perspectives de l'exercice de la profession d'infirmière*, Montréal, nouv. éd., OIIQ, 2004.

ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC. *Orientations pour une utilisation judicieuse de la règle de soins infirmiers*, Montréal, OIIQ, 2005.



222 A