INTERACTIVE CARE PLAN WORKSHEET Student Name:

NURSING DIAGNOSIS: **HYPOTHERMIA**	Patient's Medical Diagnosis:
DEFINITION:	The state in which an individual's body temperature is reduced below normal range.
DEFINING CHARACTERISTICS:	*Reduction in body temperature below normal range; *Shivering (mild); ***Cool skin**; ***Pallor (moderate**); Slow capillary refill; Cyanotic nail beds; **Hypertension**; Tachycardia; Piloerection; [If core temperature 95°F/35°C: **decreased pulse, increased respiration**, poor judgment, **memory loss**]; [If core temperature 94°-90°F/34°-32°C: all vital signs decreased, myocardial irritability/dysrhythmias, muscle rigidity, no shivering, obtunded]. * Major/critical defining characteristics.
RELATED FACTORS:	Exposure to cool or cold environment (prolonged exposure, immersion in cold water/near drowning, artificial hypothermia/cardiopulmonary bypass); Inadequate clothing; Evaporation from skin in cool environment; Inability or decreased ability to shiver; Aging (or very young); Debilitating illness or trauma; Damage to hypothalamus; Malnutrition; Decreased metabolic rate; Inactivity; Consumption of alcohol; Medications causing vasodilation (e.g., sepsis, drug overdose).
STUDENT INSTRUCTIONS:	In the space below enter the subjective and objective data gathered during your patient assessment.

ASSESSMENT

Subjective Data Entry	***Objective Data Entry***
"What happened, where am I?" *"I'm cold"*	*Temp 95 degrees, pulse 56, BP 140/90, R 32* *Pallor* *Cool skin* *Shivering* *History of hiking for 10 hours on Mt. Shasta in a climate of 24°F.*

TIME OUT!	**Student Instructions:** To be sure your patient diagnostic statement written below is accurate, you need to review the defining characteristics and related factors associated with the nursing diagnosis and see how your patient data matches. Do you have an accurate match or is additional data required or does another nursing diagnosis need to be investigated?

DIAGNOSIS

PATIENT DIAGNOSTIC STATEMENT:	**Nursing Diagnosis:** *Hypothermia* **Related to:** *Prolonged exposure to outdoors, malnutrition* **AEB:** *"S": States "I'm cold" "O": Cool skin, pallor, abnormal VS, memory loss, shivering*

PLANNING

Desired Outcome and Patient Criteria: The Patient Will*: Immediately increase body temp. 1°F/hr. until core temperature of 97°F. is reached. After reaching a core body temperature of > 97°F will continue to maintain a core body temperature of greater than 97° throughout hospital stay.*

TIME OUT! The desired outcome must meet criteria to be accurate. The outcome must be specific, realistic, measurable, and include a time frame for completion. Does the action verb describe the patient's behavior to be evaluated? Can the outcome be used in the evaluation step of the nursing process to measure the patient's response to the nursing interventions listed below?

Interventions (What you plan to do – in present tense)	***Rationale For Selected Intervention and References***
1) *Assess VS, skin, neurovascular, level of consciousness every 2 hrs, even hours, of each shift.*	1) *Hypotension can occur due to vasoconstriction,…respiratory acidosis can occur… cold stress produces bradycardia. (Doenges, p. 292)*
2) *Offer warm blankets and encourage fluids (minimum 240ml) every 2 hours, even hours of each shift.*	2) *Wrap in warm blankets,…provide warm liquids if patient can swallow. (Doenges, p.292)*
3) *Encourage resident to eat greater than 50% of all meals.*	3) *Replenishes glycogen stores and nutritional balance. (Doenges, p.294)*

EVALUATION

TIME OUT! Do your interventions assist in achieving the desired outcome? Do your interventions address further monitoring of the patient's response to your interventions and to the achievement of the desired outcome? Are qualifiers: **when, how, amount, time** and **frequency** used? Is the focus of the action's verb on the nurse's actions and not on the patient? Do your rationales provide sufficient reason and directions?

What was your patient's response to the interventions? 1) *Alert and oriented, Vital signs stable, skin warm and dry.*
2) *Patient states, "That warm blanket feels good." **3)** Patient ate 60% of lunch and 80% of dinner.*

Was the desired outcome achieved? If no, what revisions to either the desired outcome or interventions would you make?
x Yes ☐ No

DOCUMENTATION

Documentation Focus: Now that you have completed the evaluation, the next step is to document you care and the patient's response. Use the areas below to enter you progress note information. **Documentation is what you have done - in past tense.**

10/4/05 1600 #5 *(This number relates to the patient's care plan #)**:** Hypothermia R/T prolonged exposure to outdoors, malnutrition AEB:*
Cool skin, pallor, temp 95, pulse 56, BP 140/90, Resp 32, Pt statement, "What happened, where am I?", memory loss.
I1: Assessed VS, skin neurovascular, level of consciousness. E1: Alert and oriented x3, vital signs WNL, skin warm & dry-----(signature).
1800 #5: *I2: Offered warm blanket. E2: Patient stated, "That warm blanket feels good." Intake 400 ml in 4 hours. Output 200 ml in 4 hours.*
----------(Signature)
1900 #5: *I3: Encouraged resident to eat at least 50% of meal. E3: Patient ate 60% of lunch and 80% of dinner.----------(Signature).*