INTERACTIVE CARE PLAN WORKSHEET Student Name:

NURSING DIAGNOSIS: **CONSTIPATION**			Patient's Medical Diagnosis:
DEFINITION:	The state in which an individual's pattern of elimination is characterized by hard, dry stool that results from a delay in passage of food residue.		
DEFINING CHARACTERISTICS:	Decreased frequency; painful defecation; abdominal distension; abdominal pain; rectal pressure; appetite impairment; headache; hard, dry stool; straining at stool; palpable mass.		
RELATED FACTORS:	Less than adequate fluid/dietary intake; less than adequate fiber; less than adequate physical activity; immobility; lack of privacy; emotional disturbances; stress; change in daily routine; chronic use of medication and enemas; metabolic problems (hypothyroidism, hypocalcemia, hypokalemia); neuromuscular/musculoskeletal impairment; weak abdominal musculature; gastrointestinal obstructive lesions; megacolon; pain on defecation; hemorrhoids; back injury; diagnostic procedures; medication side effects/interactions; pregnancy.		
STUDENT INSTRUCTIONS:	In the space below enter the subjective and objective data gathered during your patient assessment.		
ASSESSMENT	**Subjective Data Entry**	**Objective Data Entry**	
	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:** _____ **Related to:** _____ **AEB:** _____	

PLANNING

Desired Outcome And Patient Criteria: The Patient Will:

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	Rationale For Selected Intervention and References

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?

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

Yes No

DOCUMENTATION

Documentation Focus: Now that you have completed the evaluation, the next step is to document your care and the patient's response. Use the areas below to enter your progress note information.**(Past Tense).**

INSTRUCTOR'S COMMENTS: