Refer to Chapter 2 “Assessment,” p. 65: Care Plans Developed Using The Human Needs Approach: Maslows’s Hierarchy of Needs

Client’s name: Mr. George King
Age: 68

Activity 1
Read the scenario to assist in proper identification of the client.

Activity 2
Carefully examine the pathoflow sheet for pneumonia to get a clear understanding of the pathophysiological cause and effect relationship of the client’s diagnosis (pneumonia). Begin to formulate teaching actions to help him to prevent recurrences and to better his present condition.

Activity 3
Read Mr. King’s assessment (in this appendix). Carefully develop an appreciation for the differences in the previous assessment models and compare these with this model (Human Needs Approach—Maslow’s Hierarchy).
Activity 4
Identify the five physiological needs and the three psychological needs as listed.

Activity 5
Show appreciation for safety and security as both physiological and psychological (see D—oxygenation).

Activity 6
Carefully examine the assessment of Mr. King under each need (physiological and psychological). Begin to determine how you would use this assessment model to assess another client with a different medical diagnosis.

Activity 7
Examine the individualized nursing care plans and determine reasons for prioritizing each as written.

Activity 8
Rexamine the individualized care plans, determine the sequencing and correlation between each section (ordered and selected data to evaluation). Determine reasons for recording goals met. Be sure to use this assessment format for some of the clients assigned to your care.

Note: Be aware that some physiological needs are combined in this document, for example: comfort/warmth/pain.

NURSING CARE PLAN DEVELOPED ACCORDING TO HUMAN NEEDS APPROACH—MASLOW’S HIERARCHY OF NEEDS

Scenario: Mr. George King is a 68-year-old client who had a stroke three months ago. He suffered from marked weakness of his lower extremities, which showed improvement after three days of hospitalization. He was transferred to Hill Crest Rehabilitation Center when after ten days he was assigned to home care. Because his hospital insurance was depleted, he received only one home visit. Mr. King lives alone and has only one distant relative who visited for two days during his initial hospitalization. He has been in bed since his discharge from the rehabilitation center. A neighbor found him coughing (purulent sputum), very warm to touch, and complaining of chest pain. He was pale and dehydrated. He stated he had not eaten for five days. He was soiled with both
Decreased ability to expel foreign body from respiratory tract

Prolonged illness—immobility—risk for major complications of many body systems

Altered B and T lymphocyte function

Depressed bone marrow function

Decreased production and/or impaired function of neutrophils and macrophages

Pneumococci in saliva—invades alveoli

Accumulation of large amount of fluid in alveoli

Massive multiplication of infectious organisms (pneumococci)

Damage to lung parenchyma

Dullness on percussion, rales and crackles on auscultation

Troublesome cough, purulent sputum, chest pain, fever, chills

Inflammation response

Increase in neutrophils (phagocytosis)

Stimulation and release of inflammatory mediators

Unresolved condition

Possible complications

Pleurisy
- Pleural effusion
- Atelectasis
- Delayed resolution (elderly and undernourished)
- Emphysema
- Pericarditis
- Arthritis
- Endocarditis

Red hepatization

Capillaries dilate

Organisms multiply

Exudation of WBC, fibrin and neutrophils

Multiplication of leucocytes (neutrophils and macrophages)

Gray hepatization

Accumulation of leucocytes and fibrin decreases blood flow in damaged lung parenchyma

Resolution of infectious condition

Ingestion of degenerated neutrophils, fibrin, and dead or attenuated bacteria


FIGURE B4–1 Generic pathflow sheet for pneumonia.
stool and urine on his bedclothes and on his skin. He was rushed to the hospital where he was diagnosed with pneumococcal pneumonia.

**ASSESSMENT OF MR. KING USING HUMAN NEEDS APPROACH—MASLOW’S HIERARCHY**

I. Physiological: Comfort and warmth, food and fluids, elimination, oxygenation, adequacy of pain management, adequacy of diet.

A. Comfort/Warmth and Adequacy of Pain Management

Temperature 102°F, pulse 100, respirations 36, Blood pressure 140/100, skin very warm to touch, shivering at times; complained of chest pain, stated, “I am so uncomfortable.” Complains of pain in chest aggravated by breathing and coughing. Ordered analgesia every 4 hours as needed and respiratory treatments twice a day as needed.

B. Food and Fluids, Adequacy of Diet

Has not eaten for several days, skin dry, skin turgor poor (skin when lifted over clavicle returns to normal in more than 3 seconds), hyperactive bowel sounds. Ordered soft diet. Ate only 25 percent at breakfast. Drank 100 cc of orange juice, refused other fluids. Hemoglobin 9.0 g/dl. Hematocrit 32.0 percent. States, “I am not hungry.” Having intravenous fluid (5 percent dextrose water at 42 drops per minute), absorbing without problems.

No order for special diet on first admission. Obvious weight loss. Current weight 130 lbs., height 5 feet 8 inches, body frame medium. Ideal body weight 169 lbs. States he “has no appetite and no one to cook for him.” Blood profile: Hemoglobin 9.0 g/dl. Hematocrit 32 percent. Red blood cell content $3.2 \times 10^6$ 


C. Elimination

Constipation. Dry stool on bedclothes, in client’s groin, and on buttocks. Sheets and undergarment wet with recently voided urine. Bladder not palpable.

D. Oxygenation

Color pale, respirations 36, using assessory muscles (substernal retraction) mildly diaphoretic. Crackles in both lower lung bases
on auscultation, rhonchi heard throughout lung fields. Dullness percussed above the diaphragm. Receiving oxygen by nasal canula of 3 liters per minute. Pulse oximeter readings at 85 to 90 percent with pulse rate between 100 and 120 beats per minute. Capillary refill more than 2 seconds. Nursed in semi-Fowler’s position.

E. Safety and Security (Physical and Psychological safety—Unsafe Environment, Need for Emotional Support)

Physical Environment—Physical Safety
Lives in a three-bedroom house, has bars on all windows and doors, all bedrooms upstairs. Kitchen and dining areas downstairs. There are eight steps leading from downstairs to the bedrooms. There is central heating in the house and ceiling and floor fans. There is a shower and one bathtub upstairs. Unable to ambulate.

Psychological Safety
Age 68, had a stroke, lives alone, neighbor has a key, visits occasionally. Distant relative lives out of town. Has not eaten for several days, lying in feces and urine.

II. Love and Belonging: Family and significant others (adequacy of support system) Wife died 6 months ago, had no children, one distant relative lives out of town. Neighbor visits periodically.

III. Self-esteem: Pride and worthiness (need for building self-worth)
Recounts how he worked two jobs to buy his house. Has lived in it for 20 years and as soon as it was paid for he began to take things easy, he developed a “stroke.” States his wife also died from a stroke (6 months ago). Talked of the “wonderful care she gave him.” Stated, “I want to follow her, there is nothing to live for.” Tears in eyes.

IV. Self-actualization: Goal realization, self-fulfillment (identification of life accomplishments). States, “Just as I am ready to enjoy life, my wife died of a stroke and now I am dying of a stroke. Life has dealt me a raw deal. I did pay for my house, however, now what!”
Subjective data: Breathing patterns, ineffective, related to the collection of mucus in respiratory tract; evidenced by respirations of 36 and client statement of “I am so short of breath.”

Objective data: Crackles in both lower lung bases on auscultation, ronchi heard throughout lung fields. Dulness percussed above the diaphragm. Receiving oxygen by nasal canula at 3 liters per minute, pulse oximeter readings 85–90%, pulse rate between 100 and 120 beats per minute, capillary refill more than 2 seconds. Nursed in semi-Fowler’s positions; reluctant to cough, brings up rusty tenacious purulent sputum.

---

**CLIENT:** Mr. George King  
**AGE:** 68

### Individualized Care Plan

**Using Human Needs Approach—Maslow’s Hierarchy**  
**Physiological Needs—Priority I. Oxygenation**

<table>
<thead>
<tr>
<th>Ordered &amp; Selected Data</th>
<th>Nursing Diagnosis</th>
<th>Goals</th>
<th>Interventions</th>
<th>Rationale</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
| Subjective data:       | Breathing patterns, ineffective, related to the collection of mucus in respiratory tract; evidenced by respirations of 36 and client statement of “I am so short of breath.” | Short term: Client will admit and demonstrate easier breathing. Respirations will be between 28 and 30 within 30 minutes after intervention. Long term: Use of accessory muscles will be less marked. Crackles and ronchi will be less evident. Pulse oximeter reading will be between 90–100 by the end of the shift (1500). | - Continue to nurse in semi-Fowler’s position.  
- Keep nasal canula properly positioned in anterior nares at all times to facilitate adequate delivery of oxygen.  
- Offer 100 to 120 cc of fluids every hour (increase as client tolerates or is willing to take).  
- Teach deep breathing, coughing and expectoration (have client support rib cage with palms of hands, breathe in deeply and cough on exhalation—repeat every 1 to 2 hours).  
- Promotes lung expansion.  
- Supplemental oxygen replaces depleted cellular oxygen; promotes easier breathing and increases oxygen saturation in arterial blood.  
- Water liquefies secretions (decreases tenacity) bathes tissue, provides comfort, and enables sputum production and liquefaction.  
- Promotes more effective cough and the removal of mucus from the lungs. | Short-term goal met: Client’s respirations were 28 about 20 minutes after administration of pain medication, water, and coughing and expectoration exercises (oxygen, Fowler’s position, intravenous therapy, medication given as ordered). Client stated “My breathing is so much better, thank you.” Long-term goals met: By the end of the shift (1500) the client was sleeping, respirations were markedly reduced, pulse oximeter readings were between 90 and 100, crackles and ronchi less marked on auscultation. Client expectorating mucus (less tenacious and rusty), continues. |
### Ordered & Selected Data

### Nursing Diagnosis
- Restlessness
- Cyanosis

### Goals

### Interventions
- Teach proper use of incentive inspirometer if ordered (place mouth tightly around mouth piece, inhale slowly, raise piston to desired level, exhale slowly, only partially remove mouth piece and complete exhalation, repeat between 5 and 6 times and continue every hour.
- Feed well-balanced diet.
- Administer IV fluids as ordered, ambulate as ordered. Administer all ordered medications (expectorants, antibiotics, and antipyretics).

### Rationale
- Aids lung expansion and helps to determine adequate inspiration.
- Balanced diet provides energy and healing properties, and strengthens the immune system.
- IV fluids prevent/correct dehydration and aid electrolyte balance. Ambulation, a form of exercise, prevents immobility thus preventing many complications. Expectorants aid the expulsion of mucus from the respiratory tree. Antibiotics destroy destructive organisms.

### Evaluation
- Temperature 99.6°F, pulse 86 to 90.

---

Subjective data: Client complained of chest pain, stated “I am so uncomfortable.”

Objective data: Lying in semi-Fowler’s position, guarding chest with hand. Skin warm to touch, shivering at times. Temperature 102°F. Pulse 100. Respirations 36. Blood pressure 140/100. Grimacing when attempting to cough.

---

### Individualized Care Plan

#### Using Human Needs Approach—Maslow’s Hierarchy

#### Physiological Needs—Priority II Comfort and Warmth and Adequacy of Pain Management

<table>
<thead>
<tr>
<th>Ordered &amp; Selected Data</th>
<th>Nursing Diagnosis</th>
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<th>Evaluation</th>
</tr>
</thead>
</table>
| **Subjective data:**   | Pain, acute related to damaged lung parenchyma evidenced by verbal complaints and grimacing when attempting to cough, elevated pulse, respirations, and blood pressure. | **Short term:** Client will verbalize reduction in pain from 10 (on a scale of 0–10) within 30 minutes of administration of analgesia (dependent intervention) and other nursing interventions (independent). | Independent  
- Have client rate pain on scale of 0–10.  
- Inform client of nonpharmacologic methods to relieve pain:  
  - Adjust to position of comfort.  
  - Breathe easily and slowly (in through nose, out through pursed lips).  
  - Splint chest when coughing.  
  - Take small amounts of fluid at least every hour.  
  - Maintain oxygen in place (nasal canula).  
  - Expectorate after each coughing spell.  
  - Use distraction to prevent focusing on pain—television, music (radio in room), guided imagery. |  
- Provides understanding of the client’s perception of the severity of the pain (pain is subjective).  
- Understanding of the plan of care and involvement in the therapeutic regimen will foster acceptance, eliminate or decrease the feeling of powerlessness, and foster recovery. | Short-term goal met: Client listened attentively to the teaching session. Demonstrated techniques taught and stated pain was less about 20 minutes after the interventions (nonpharmacologic and pharmacologic). |
| **Objective data:**     | Defined characteristics: Acute pain  
- Client reports pain  
- Facial expression of pain (grimacing)  
- Guarding behavior  
- Increased blood pressure  
- Increased pulse rate in morning  
- Change in eating habits | **Long term:** Client will rate pain not above 2 (scale 0–10) throughout the day. Client will engage in activities of daily living (eating). Client will demonstrate comfort (absence of grimacing and protective behavior). Skin will be cool to touch with an absence of shivering. Client will admit comfort. | Dependent  
- Pharmacological  
  - Inform client of available analgesic and frequency of administration.  
  - Instruct client to ask for pain medication before pain becomes severe  
  - Administer analgesic around the clock (every 4 hours as ordered).  
  - Cold compress on forehead. |  
- Analgesic when given on a regular basis will keep pain controlled. | Long-term goals met: Client ate poorly at breakfast, but drank 100 to 120 cc of fluids every hour. Ate 50% of diet at lunch and 75% of evening meal. Temperature 100.8°F Respirations 28 Pulse 88 Blood pressure 130/88 Admitted feeling comfortable, no further grimacing. |

---

Subjective data:
Client states: "I have not eaten for several days" and "I am not hungry."

Objective data:
Poor skin turgor. Anorectic (ate 25 percent of breakfast, drank 100cc orange juice, refused other fluids). Hemoglobin 9.0 (normal 13.5–18 g/dl). Hematocrit 32.0 normal (40–54%). Receiving intravenous fluids (5% dextrose water at 42cc per hour).

Nutrition, imbalanced, less than body requirement related to infectious state (temperature 102°F) evidenced by: anorexia, poor skin turgor, Hemoglobin of 9.0, Hematocrit of 32.0, and hyperactive bowel sounds.

Defining characteristics: Hyperactive bowel sounds Weight loss more than 20% below ideal body weight Anorexia Poor muscle tone Pale conjunctiva Alopecia

### Individualized Care Plan

Using Human Needs Approach—Maslow’s Hierarchy

#### Physiological Needs—Priority III Foods and Fluids: Adequacy of Diet

<table>
<thead>
<tr>
<th>Ordered &amp; Selected Data</th>
<th>Nursing Diagnosis</th>
<th>Goals</th>
<th>Interventions</th>
<th>Rationale</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective data:</td>
<td>Nutrition,</td>
<td>Short term:</td>
<td>Inform client that:</td>
<td>Having adequate information about the therapeutic regime and becoming involved in the plan of care will create a feeling of ownership and decrease powerlessness.</td>
<td></td>
</tr>
<tr>
<td>Client states:</td>
<td>imbalanced,</td>
<td>Client will verbalize the importance that food and fluids play in lowering temperature and improving health.</td>
<td>—Fluids will liquefy mucous in lungs, aiding congestion —Proper nutrition will strengthen immune system and aid in fighting infection.</td>
<td>Short-term goal met: Client demonstrated readiness to learn and actively participated in the plan (frequent drinking, sharing of feelings, and eating).</td>
<td></td>
</tr>
<tr>
<td>&quot;I have not eaten for several days&quot; and</td>
<td>less than body requirement related to infectious state (temperature 102°F) evidenced by:</td>
<td>Client will drink 100–120 cc of fluid every hour.</td>
<td>Offer frequent small amounts of fluid (about 100–120cc every hour).</td>
<td>Long-term goal met: Client ate approximately 80% of meal by second day. Blood profile showed positive changes by 3rd day.</td>
<td></td>
</tr>
<tr>
<td>&quot;I am not hungry.&quot;</td>
<td>anorexia,</td>
<td>Client will identify food likes and dislikes.</td>
<td>Encourage client to feed self—provide straw.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective data:</td>
<td>poor skin turgor,</td>
<td>Long term:</td>
<td>Help client choose foods inclusive of his idiosyncrasies.</td>
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<tr>
<td>Poor skin turgor.</td>
<td>Hemoglobin of 9.0,</td>
<td>Client will eat at least 50% of all meals by second day and 75% by day 3.</td>
<td>Serve foods attractively, provide enough time for eating, assist client as necessary.</td>
<td>Client gained about a half pound a day. Fluid intake equaled output by day 3.</td>
<td></td>
</tr>
<tr>
<td>Anorectic (ate 25 percent of breakfast, drank 100cc orange juice, refused other fluids).</td>
<td>Hematocrit of 32.0</td>
<td>Client will demonstrate steady weight gain beginning on day 3.</td>
<td>Serve small meals. Provide mouth rinses before meals (lemon/lime).</td>
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<tr>
<td>(normal 40–54%).</td>
<td>and hyperactive</td>
<td>Client will show increase in hemoglobin and hematocrit by day 3 and bowel sounds will be normal.</td>
<td>Include iron-rich foods.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving intravenous</td>
<td>bowel sounds</td>
<td>Client will voice interest in food.</td>
<td>Record intake.</td>
<td></td>
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</tr>
<tr>
<td>fluids (5% dextrose</td>
<td>Weight loss</td>
<td></td>
<td>Weigh daily as ordered.</td>
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<tr>
<td>water at 42cc per hour)</td>
<td>more than 20%</td>
<td></td>
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<tr>
<td>ideal body weight</td>
<td>below ideal body weight</td>
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<tr>
<td>Anorexia</td>
<td>Poor muscle tone</td>
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<tr>
<td>Pale conjunctiva</td>
<td>Alopecia</td>
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</tbody>
</table>

### Individualized Care Plan

#### Using Human Needs Approach—Maslow’s Hierarchy

**Physiological Needs**—**Priority IV** **Elimination**—**Urination**

<table>
<thead>
<tr>
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<th>Interventions</th>
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</thead>
<tbody>
<tr>
<td>Subjective data: Client states “Please excuse me for the state I am in; I cannot help myself.”</td>
<td>Skin integrity impaired, risk for related to immobility and incontinence of urine.</td>
<td>Short term: Client will discuss ways to prevent skin breakdown. Long term: Client will maintain intact skin (free of excessive redness or decubitus ulcers).</td>
<td>• Inform client that: —Lying in one position for a prolonged period of time can create trauma to the area (initial redness and later skin break). —These ulcers can become severe, infectious, and difficult to heal. Client will discuss ways of preventing decubitus ulcers: • Turn every 2 hours. • Take daily baths. • Cleanse perineal area thoroughly after each voiding or defecation. • Sit in chair for meals when allowed. • Take walks in hall at least 2 times a day as allowed. • Drink at least 3 liters of fluids a day. • Eat foods high in protein, carbohydrates, minerals, and vitamins. • Report wetness or discomfort at pressure sites (bony prominences). • Teach kegel exercises. Instruct client to perform these every hour. • Assist client with all aspects of care.</td>
<td>• The informed client is more likely to cooperate with the plan of care.</td>
<td>Short-term goal met: Client verbalized intent to cooperate with all aspects of care. Long-term goal met: Ambulated in hallway using wheelchair. Marked improvement in appetite, drinking fluids lavishly. Voices need to void, uses urinary efficiently. No further sign of urinary incontinence. Skin remained intact. No skin breakdown.</td>
</tr>
<tr>
<td>Objective data: Dry stool in groin on bedclothes and on buttocks. Sheet and undergarment wet with recently voided urine.</td>
<td>Defining characteristics: Break in epidermis and/or dermis Marked erythema of skin Increased warmth to area Serosanguineous bloody discharge or pus</td>
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</tbody>
</table>

**CLIENT:** Mr. George King  
**AGE:** 68
**CLIENT: Mr. George King**
**AGE: 68**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Subjective data: Client states “Please excuse me for the state I am in: I cannot help myself.”</td>
<td>Contipation, risk for altered elimination related to immobility.</td>
<td>Short term: Client will state the importance of having a regular bowel movement.</td>
<td>Tell client that regular bowel movements are necessary to prevent stool becoming hard and dry, straining and bleeding, abdominal pain, and excess gas formation.</td>
<td>Insight into health principle will create positive outlook.</td>
<td>Short-term goal met: Client demonstrated readiness to learn and stated “I never knew the passing of stool had so much related to it.”</td>
</tr>
</tbody>
</table>
| Objective data: Dry stool on bedclothes, in groin, and on buttocks. Stool moderately hard, small to moderate amount. | Defining characteristics: Decrease in frequency of defecation. Hard consistency of stool, difficult to pass (stays in rectum). Abdominal distension. Increased flatulence. Headache. Palpable mass. | Long term: Client will have one bowel movement daily or at least one in 3 days (soft in texture and moderate to large in size). | Inform client of the interventions that will enable him to defecate regularly:  
— Exercise—Adequate fluid intake.  
— Eating foods that contain bulk.  
— Defecate on urge—Use laxatives and enemas only when ordered. Turn client at least every 2 hours. Sit in chair for meals as ordered. Assist client to walk as ordered. Provide 100–120cc of fluid every hour, increase amount as tolerated to total of 3 liters per day. Feed foods high in fiber. Assist client to have a bowel movement during urge (approximately the same time every day). Record frequency of stool and consistency. | Understanding of the therapeutic regimen and involvement in the plan of care will enhance commitment, strengthen motivation, and decrease or eliminate the feeling of powerlessness. | Long-term goal met: Client cooperated with all nursing procedures, demonstrated satisfaction. Had one bowel movement every day starting with the second day. Expressed joy over the care he received. Stated, “I will continue all this when I go home.” Ambulates with walker alone. |

CLIENT: Mr. George King  
AGE: 68

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</tr>
</thead>
<tbody>
<tr>
<td>Subjective data: Client states “Wife died 6 months ago. Had no children. One distant relative lives out of town. Neighbor visits periodically. Please forgive me, I cannot help myself.”</td>
<td>Social isolation evidenced by verbalization of loss and powerlessness. Defining characteristics: Absence of significant others (wife and distant relative) Expresses feelings of being alone Voices death wish Apologetic of present condition Expresses hopelessness and powerlessness</td>
<td>Short term: Client will identify the social benefits of living in the Northside Nursing Home. Long term: Client will identify hobbies and skills that can be practiced and later shared with nursing home residents.</td>
<td>• Share information about the residents and the activities in the Northside Nursing Home; age group, daily activities, extracurricular and individualized activities. Observe client’s reaction, confront negative behaviors, comment on positive ones. • Have client keep a log of hobbies (able to use upper extremities) and other skills in which he engaged through the years. Review log and give positive feedback every day.</td>
<td>• Previous knowledge of activities and environmental conditions will create readiness (for admission to Northside Nursing Home) and decrease anxiety. • Recalling of previous strengths and accomplishments will create satisfaction and acceptance of self and convey the desire to again be a contributing member of society (among Northside Nursing Home residents) and enhance self-esteem.</td>
<td>Short-term goal met: Client listened attentively to the information shared about the Northside Nursing Home. Pamphlet with information provided. Looked at physical structure and stated “This is a good-looking home” (began to identify). No high anxiety behavior manifested. Long-term goal met: Kept red notebook on bedside stand, documentation made daily; reminded nurse to read log. Nurse and client used project as favorable past time each day.</td>
</tr>
</tbody>
</table>

## Individualized Care Plan

### Using Human Needs Approach—Maslow’s Hierarchy

#### Safety and Security Needs

<table>
<thead>
<tr>
<th>Ordered &amp; Selected Data</th>
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<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective data:</td>
<td>Injury, risk for:</td>
<td>Short term: Psychological:</td>
<td>• Provide atmosphere for open communication: quiet room, comfortable temperature, clean clothes and bed, adequate food intake, unhurried demeanor. Help client share his deep-seated feelings about his current living situation. Use empathy, effective listening, clarification, restatement, simple questions, and tactile communication.</td>
<td>• Provides for sharing of information (intimate thoughts). Develops trust relationship.</td>
<td>Short-term goal met: Psychological: Client talked about his fear of being alone and how helpless he felt. Discussed his inability to call the neighbor especially at night. Stated he thought “death was better than this.”</td>
</tr>
<tr>
<td>Client states</td>
<td>Psychological (depression)</td>
<td>Psychological: Client will verbalize his feelings about being alone. Client will explore the possibility of the distant relative coming to live with him. Client will explore the possibility of a caretaker living with him. Client will explore the need for moving to another living facility such as a nursing home.</td>
<td>• Ask probing questions about others living with him—distant relative, homemaker. • Discuss potential safety problems of living in current home. • Ask about any desire to see social worker to explain possible alternatives and available help.</td>
<td>• Provides database for further nursing action.</td>
<td>Long-term goal met: Physical and Psychological: Social worker visited. Discussed his Medicare coverage and his pension; informed client that there were adequate funds to pay for his living expenses in Northside Nursing Home. Client complied. Sustained no physical trauma.</td>
</tr>
<tr>
<td>“I live alone, my neighbor has a key and visits occasionally. One distant relative lives out of town. I have not eaten for several days, forgive me for the state I am in, I cannot help myself.”</td>
<td>Physiological (trauma) related to preoccupation with loneliness (social isolation), falls attempting to crawl upstairs, and accessibility of health care and fire personnel to reach him on time if an emergency develops.</td>
<td>Long term: Physiological: Client will be free of physical injury. Psychological: Client will express satisfaction with his living arrangements.</td>
<td>• Provides collaboration with experts in the health care arena. Facilitates specialized and comprehensive client care.</td>
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<tr>
<td>Objective data:</td>
<td>Defining characteristics: Anticipation of helplessness Inability to summon help after a fall or other emergency Lower extremity dysfunction Self-care deficit: bathing/hygiene, dressing/grooming, feeding, toileting.</td>
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<tr>
<td>Age, 68</td>
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<tr>
<td>Stool and urine in groin and on buttocks. Lives in three bedroom house, has bars on all windows and doors, all bedrooms upstairs. Eight steps to climb from downstairs to upstairs, kitchen is downstairs. Unable to ambulate.</td>
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</tbody>
</table>

**Reference:**
CLIENT: Mr. George King  
AGE: 68

### Individualized Care Plan

**Using Human Needs Approach—Maslow’s Hierarchy**

#### Self-Esteem Needs

<table>
<thead>
<tr>
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| Subjective data:        | Self-esteem disturbance—situational—low. | Short term: Client will voice at least three wishes about self. | • Provide atmosphere conducive to verbalization:  
—Unhurried demeanor  
—Tactile communication  
—Empathy  
—Expectancy  
—Humor (remember to use appropriately, assess the situation before you smile or laugh) | Provides data for intervention. | Short-term goal met: Client willing to talk. |
| Client states:          | Defining characteristics: Voices self-failure Self-negating Passivity Expression of powerlessness Voices desire to die. Emotional disturbances (crying) | Long term: Client will identify at least one enabling intervention for realizing each wish. | • Ask client: “If you had one wish what would it be?” (allow time for response). Then say, “and two?” (allow time for response). Then say “and three?” (allow time for response).  
• Reread wishes to client and have him prioritize (urgent desire, second, and third).  
• Develop a plan of care (collaborate) for the accomplishment of each wish. | —Humor can express identification with the verbalized report and aids relaxation (decreases anxiety, builds trust). Humor can be detrimental, use with caution.  
• Identification of a direct wish encourages exploration of thought and generates self-assurance, acceptance, and the thought of worthiness among others, in this case the nurse.  
• Writing each wish connotes empathy, interest, and understanding in the client’s affairs.  
• Rereading, prioritizing, and planning encourages partnership and confidence. | Long-term goal met: Identified first wish as “desire to walk again.” Client reminded that he was only 68 years old, that the weakness in his legs (stroke) had improved enough for him to be discharged home, and that the lack of assistance and the pneumonia had compounded his problem. Nurse informed client that physiotherapy would begin in this hospital and continue in the Northside Nursing Home and that his legs would likely grow stronger and stronger. Identified second wish as a desire to go to work again, even part time. Mobile transportation discussed and the possibility of Medicare equipping him with an electric chair. Also discussed his finding a job at Northside. Identified visitation to his wife’s grave as his third wish. Informed that the social worker would include this requirement as part of his extracurricular activities while in Northside Nursing Home. The client voiced satisfaction in the future plan; both client and nurse had a fourth wish that he would walk again unaided. |
| “As soon as my house was paid for and I thought of taking things easy, I developed a stroke. My wife also died from a stroke 6 months ago. She gave me such wonderful care. I want to follow her.” | | | | |

Objective data:  
Tears in eyes.

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### CLIENT: Mr. George King
**AGE: 68**

#### Individualized Care Plan
**Using Human Needs Approach—Maslow’s Hierarchy**
**Self Actualization Needs**

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<td>Client states “Just as I am ready to enjoy life my wife died of a stroke and now I am dying of a stroke. Life has dealt me a raw deal; I did pay for my house, however, now what?”</td>
<td>Self-mutilation—risk for.</td>
<td>Short term: Client will identify self as middle adult age (40–68). Client will identify number of productive years that are still possible. Client will rehearse the things he would have done if his wife had not died and he had not had a stroke.</td>
<td>• Explore client’s previous lifestyle, diet, work, rest, sleep, and spirituality. • Teach moderation and appropriate diet with 6–8 glasses of water daily and a planned exercise regimen when he begins to walk again.</td>
<td>• Exploration provides baseline data for nursing intervention. • Information contributes to knowledge base and change in behavior.</td>
<td>Short-term goal met: Client expressed interest in the age dimension—thought 68 years was very old. Client stated he believed he could still be active at 80 years old.</td>
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<td>Defining characteristics: Loss of significant other (wife) Inability to express grief Alterations in sexuality (loss of sexual partner) Persistent low self-esteem Altered body image Inability to plan long-term goals Depression Unrealistic goal planning Fear of the unknown</td>
<td>Long term: Client will identify the factors he believed caused the stroke. Client will discuss change in lifestyle habits. Client will discuss accomplishments, and his previously desired goals beyond 68 years.</td>
<td>• Encourage planning positively and realistically. • Encourage client to have hope for the future and write down the things he wants to accomplish until he becomes an older adult.</td>
<td>• Encouragement builds self-esteem. • Writing aids in the setting of goals.</td>
<td>Stated he wanted to travel to Europe, Australia, and probably the Caribbean, said the travel club was a good idea. Stated, “I am sorry I got sick, but I believe I can turn my life around from here. Thank you, I might be able to marry again, someday. I wish my wife knew all these things, she might not have died.”</td>
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**Long-term goals met:**
- Stated his diet consisted mainly of hamburgers, pizzas, and soft drinks. Admitted drinking “a lot of beer, some alcohol, and smoked about a pack of cigarettes a week.” 24-hour recall done; rehearsed with client; low-fat, balanced diet with minimum salt and 6 to 8 glasses of water discussed.
- Admitted sleeping only 4 hours a day, since he worked 2 jobs. Denied exercising on a regular basis. Verbalized desire to comply.