State-Approved Curriculum
NURSE AIDE I TRAINING PROGRAM
July 2013
Module M

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Registry Section
Center for Aide Regulation and Education

Module M – The Nursing Process and Nursing Care Plan
Teaching Guide

Objectives

- Identify the role of the nurse aide in each step of the nursing process.
- Describe the importance of a resident's nursing care plan.

Advance Preparation – In General

- Review curriculum and presentation materials
- Add examples or comments to Notes Section
- Set up computer/projector

Module M – The Nursing Process and Nursing Care Plan
Definition List

Assessment – first step of nursing process; collecting information about a resident

Evaluation – fifth step of nursing process; deciding if nursing measures worked or were effective, and whether goal was met

Implementation – fourth step of nursing process; nursing measures carried out during resident care

Kardex – a type of card file that includes information important to the care of residents and includes drugs, treatments, diagnoses, routine care measures, and special needs

Nursing Care Plan (or the care plan) – individualized, written plan of care for residents based on nursing process written by the nurse and used for coordination and continuity of care

Nursing Diagnosis – second step of nursing process; a health problem that nurses can treat using nursing measures

Nursing Process – method used by nurses to plan and deliver nursing care to the resident

Planning – third step of nursing process; setting of resident goals that are prioritized

Module M – The Nursing Process and Nursing Care Plan

(S-1) Title Slide

(S-2) Objectives

1. Identify the role of the nurse aide in each step of the nursing process.
2. Describe the importance of a resident's nursing care plan.

Content	Notes

(S-3) Nursing Process
• Method used by nurses to plan and deliver nursing care to the resident
• Five steps are
  o Assessment – collecting information about a resident
  o Nursing diagnosis – a health problem that nurses can treat using nursing measures
  o Planning – setting of resident goals that are prioritized
  o Implementation – nursing measures carried out during resident care
  o Evaluation – deciding if nursing measures worked or were effective, and whether goal was met
• Different from what the doctor does regarding care of resident
• A type of game plan for resident care and not simply, hit and miss	

TEACHING TIP #1M: Nursing Process Example Provide a simple example of the nursing process in use.	
(S-4) Nursing Care Plan • Is sometimes simply called the care plan • Responsibility of nurse to provide individualized, written plan of care for residents • Based on nursing process • Used for coordination and continuity of care throughout the day and on a day-to-day basis, for each resident • May be standardized, computerized, or written in Kardex o Kardex – a type of card file that includes information important to the care of residents and includes drugs, treatments, diagnoses, routine care measures, and special needs	
(S-5) The Nursing Process and Nursing Care Plan – Importance • Nursing care of the resident is organized, individualized, and has purpose • Nursing care is consistent and nurses/nurse aides know what is expected to be done • Resident feels safe and secure because care is consistent • Nursing care plan assists health team members to deliver quality consistent care to residents. Time spent performing unneeded tasks and care wastes money, resources, and time	
(S-6) The Nursing Process and Nursing Care Plan – Nurse Aide's Role	

Module M – The Nursing Process and Nursing Care Plan	
• Cannot perform assessments, but can assist nurse during data collection, such as obtaining heights and weights, vital signs, recording intake and output; need to report timely and accurate data • Nursing diagnoses based on data collected and nurse aides often collect data used by nurse to create nursing diagnoses • Interventions are often what nurse aides do, such as turning, repositioning, toileting, etc. documenting accurately assists the nurse with evaluating interventions • If intervention does not work, nurse modifies nursing care plan • Most important part during intervention stage is to accurately report reactions to interventions • Evaluation is time when nurses look at nursing care plans and see if plan worked in solving health issues and if interventions effective • Nurse relies on observations by nurse aides to assist with evaluation	
(S-7) THE END	